A NONSUBSTANTIVE REVISION
OF STATUTES RELATING TO
INSURANCE FEES AND TAXES, CONSUMER INTERESTS,
HEALTH INSURANCE AND RELATED PRODUCTS, TITLE INSURANCE,
AND INSURANCE INDUSTRY PROFESSIONALS

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(f) Claim information provided by an employer carrier under this section shall be provided in the aggregate, without information through which a specific individual covered by the health insurance or evidence of coverage may be identified.

Revised Law

Sec. 1501.615. ADDITIONAL REPORTING REQUIREMENTS. The department may require periodic reports by large employer health benefit plan issuers and agents regarding the large employer health benefit plans issued by those issuers. The reporting requirements must:

(1) require information regarding the number of plans in various categories that are marketed or issued to large employers; and

(2) comply with federal law, including regulations. (V.T.I.C. Art. 26.91, Subsec. (b).)

Source Law

(b) The department may require periodic reports by large employer carriers and agents regarding the large employer health benefit plans issued by those carriers. The reporting requirements must require information regarding the number of large employer health benefit plans in various categories that are marketed or issued to large employers and must comply with federal law and regulations.

Revised Law

Sec. 1501.616. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a large employer health benefit plan issuer enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to offering large employer health benefit plans to large employers in this state, the third-party administrator is subject to this subchapter and Subchapter C. (V.T.I.C. Art. 26.95.)

Source Law

Art. 26.95. If a large employer carrier enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to the offering of large employer health benefit plans to large employers in this state, the third-party administrator is subject to this subchapter.

CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

SUBCHAPTER A. GENERAL PROVISIONS

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SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1502.001. APPLICABILITY OF CHAPTER. This chapter applies only to the issuer of a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act or another analogous benefit arrangement; or

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 27.02.)

Source Law

Art. 27.02. This chapter applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002) or another analogous benefit arrangement; or

(ii) any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk sharing basis, including an entity that contracts for health care services on a capitation basis; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

(1) V.T.I.C. Article 27.02(1)(B)(ii) refers to a health benefit plan offered by an entity that is not "licensed" under the Insurance Code or another

insurance law of this state. The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

(2) V.T.I.C. Article 27.02(2) refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits the reference to the commissioner issuing the certificate of authority as unnecessary because Chapter 844 requires the commissioner to issue the certificate of authority.

(3) V.T.I.C. Article 27.01 defines "health benefit plan." The revised law omits the definition as unnecessary because V.T.I.C. Article 27.02, revised as Section 1502.001, specifies the types of health benefit plans that may be issued by a health benefit plan issuer to which the chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> Art. 27.01. In this chapter, "health benefit plan" means a health benefit plan described by Article 27.02 of this code.

Revised Law

Sec. 1502.002. RULES. The commissioner may adopt rules to implement this chapter. (V.T.I.C. Art. 27.06.)

Source Law

Art. 27.06. The commissioner may adopt rules to implement this chapter.

[Sections 1502.003-1502.050 reserved for expansion]

SUBCHAPTER B. CHILDREN'S HEALTH BENEFIT PLAN

Revised Law

Sec. 1502.051. CHILDREN'S HEALTH BENEFIT PLAN. A health benefit plan issuer may offer a children's health benefit plan that provides coverage only to children younger than 18 years of age. The issuer may offer the plan only if the commissioner approves the plan's structure and the benefits offered under the plan. (V.T.I.C. Art. 27.03.)

Source Law

Art. 27.03. (a) The issuer of a health benefit plan may offer a children's health benefit plan in accordance with this chapter. The health benefit plan may provide coverage only to children younger than 18 years of age.

(b) An issuer of a health benefit plan may not offer a children's health benefit plan under this chapter unless the plan's structure and the benefits offered under the plan have been approved by the commissioner.

Revised Law

Sec. 1502.052. MANDATED BENEFIT PROVISIONS INAPPLICABLE. A children's health benefit plan is not subject to any law that requires coverage or the offer of coverage of a health care service or benefit. (V.T.I.C. Art. 27.04.)

Source Law

Art. 27.04. A children's health benefit plan is not subject to a law that requires coverage or the offer of coverage of a health care service or benefit.

Revised Law

Sec. 1502.053. EXEMPTION FROM CERTAIN TAXES. A children's health benefit plan issuer is not subject to the premium tax or the tax on revenues imposed under Chapter 222 with respect to money received for coverage provided under that plan. (V.T.I.C. Art. 27.05.)

Source Law

Art. 27.05. The issuer of a children's health

benefit plan is not subject to the premium tax imposed by Article 4.11 of this code or the tax on revenues imposed under Section 33, Texas Health Maintenance Organization Act (Article 20A.33, Vernon's Texas Insurance Code), with respect to money received for coverage provided under that plan.

CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

Revised Law

Sec. 1503.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) an analogous benefit arrangement; or

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) another entity that:

(i) is not authorized under this code or another insurance law of this state; and

(ii) contracts directly for health care services on a risk-sharing basis, including a capitation basis. (V.T.I.C. Art. 21.24-2, Sec. 2(a).)

Source Law

[Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.]

Sec. 2. (a) This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that is certified under Section 162.001, Occupations Code, and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code; or

(3) is offered by any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis.

Revisor's Note

(1) Section 2(a)(2), V.T.I.C. Article 21.24-2,

refers to an approved nonprofit health corporation that is "certified under Section 162.001, Occupations Code," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 162.001, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under Section 162.001, Occupations Code, as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner's issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

(2) Section 2(a)(3), V.T.I.C. Article 21.24-2, refers to a health benefit plan offered by an entity not "licensed" under this code or another insurance law of this state. The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

Revised Law

Sec. 1503.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),

as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1503.001. (V.T.I.C. Art. 21.24-2, Sec. 2(b).)

Source Law

[Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.]

[Sec. 2]

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to liability insurance;

(2) a small employer health benefit plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS. (a) A health benefit plan may not condition coverage for a child younger than 25 years of age on the child's being enrolled at an educational institution.

(b) A health benefit plan that requires as a condition of coverage for a child up to 25 years of age that the child be a full-time student at an educational institution must provide the coverage:

(1) for the entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student; and

(2) continuously until the 10th day of instruction of the subsequent academic term, on which date the health benefit plan may terminate coverage for the child if the child does not return to full-time student status before that date.

(c) For purposes of this section, determination of the full-time student status of a child is made in the manner provided by the educational institution at which the child is enrolled. (V.T.I.C. Art. 21.24-2, Sec. 3.)

Source Law

> Sec. 3. (a) Each health benefit plan that conditions coverage for a child up to 25 years of age on the child's being a full-time student at an educational institution shall provide the coverage for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student. Additionally, the health benefit plan shall provide the coverage continuously until the 10th day of instruction of the subsequent academic term on which date the health benefit plan may terminate coverage of the child if the child does not return to full-time student status before that date. A health benefit plan may not condition coverage for a child younger than 25 years of age on the child's being enrolled at an educational institution.
>
> (b) For purposes of this section, determination of the full-time student status of a child subject to this article is made in the manner provided by the educational institution at which the child is enrolled.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.24-2, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1503.001 and 1503.002, specifies the types of health benefit plans to which this chapter applies, and thus the defined term is not

helpful to the reader. The omitted law reads:

> Art. 21.24-2
> Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1504. MEDICAL CHILD SUPPORT

SUBCHAPTER A. GENERAL PROVISIONS

CHAPTER 1504. MEDICAL CHILD SUPPORT

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1504.001. DEFINITIONS. In this chapter:

(1) "Child" has the meaning assigned by Section 101.003, Family Code.

(2) "Child support agency" has the meaning assigned by Section 101.004, Family Code.

(3) "Custodial parent" means an individual who:

(A) is a managing conservator of a child or a possessory conservator of a child who is a parent of the child; or

(B) is a guardian of the person or other custodian of a child and is designated as guardian or custodian by a court or administrative agency of this or another state.

(4) "Health benefit plan issuer" means:

(A) an insurance company, group hospital service corporation, or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or agreement, a group hospital service contract, or an evidence of coverage that provides benefits for medical or surgical expenses incurred as a result of an accident or sickness;

(B) a governmental entity subject to Subchapter D, Chapter 1355, Subchapter C, Chapter 1364, Chapter 1578, or Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5;

(C) the issuer of a multiple employer welfare arrangement as defined by Section 846.001; or

(D) the issuer of a group health plan as defined by Section 607, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1167).

(5) "Medical assistance" means medical assistance under the state Medicaid program. (V.T.I.C. Art. 3.96-1.)

Source Law

Art. 3.96-1. In this subchapter:

(1) "Child" has the meaning assigned by Subsections (a) and (b), Section 101.003, Family Code.

(2) "Child support agency" has the meaning assigned by Section 101.004, Family Code.

(3) "Custodial parent" means:

(A) a managing conservator of a child or a possessory conservator of a child who is a parent of the child; or

(B) a guardian of the person of a child, or another custodian of a child if the guardian or custodian is designated by a court or administrative agency of this or another state.

(4) "Health insurer" means any insurance company, group hospital service corporation, or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides benefits for medical or surgical expenses incurred as a result of an accident or

sickness.

(5) "Insurer" means:

(A) a health insurer;

(B) a governmental entity subject to:

(i) Article 3.51-1, 3.51-2, 3.51-4, 3.51-5, or 3.51-5A of this code; or

(ii) Section 1, Chapter 123, Acts of the 60th Legislature, Regular Session, 1967 (Article 3.51-3, Vernon's Texas Insurance Code);

(C) a multiple employer welfare arrangement, as that term is defined by Article 3.95-1 of this code; or

(D) a group health plan, as defined by Section 607(1), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1167).

(6) "Medical assistance" means medical assistance under the state Medicaid program.

Revisor's Note

Subdivision (5), V.T.I.C. Article 3.96-1, defines "insurer" to include the defined term "health insurer." "Health insurer" is a term used in conjunction with traditional health insurance. Included in the definition of "health insurer" are entities such as health maintenance organizations, which are not traditional insurers. Consequently, "health benefit plan issuer" is a more accurate term than "insurer," and throughout this chapter, the revised law substitutes "health benefit plan issuer" for "insurer." In addition, because the term "health insurer" is only used in the definition of "insurer," the revised law omits the definition of "health insurer" and includes the substance of the definition in the definition of "health benefit plan issuer." Comparable changes necessary to ensure consistent terminology have been made throughout the chapter.

Revised Law

Sec. 1504.002. RULES. (a) The commissioner shall adopt reasonable rules as necessary to implement this chapter and 42 U.S.C. Section 1396a(a)(60), including rules that define acts that constitute unfair or deceptive practices under Subchapter I, Chapter 541.

(b) The commissioner shall adopt rules that define

"comparable health coverage" in a manner that:

(1) is consistent with federal law; and

(2) complies with the requirements necessary to maintain federal Medicaid funding. (V.T.I.C. Art. 3.96-8, Sec. (c); Art. 3.96-10.)

Source Law

[Art. 3.96-8]
(c) The commissioner shall adopt rules to define "comparable coverage" in a manner consistent with federal law and that meet requirements to maintain federal Medicaid funding.

Art. 3.96-10. The commissioner shall adopt reasonable rules as necessary to implement this subchapter and the requirements of 42 U.S.C. Section 1396a(a)(60), including rules defining acts that constitute unfair or deceptive practices under Section 13, Article 21.21, of this code.

Revisor's Note

Section (c), V.T.I.C. Article 3.96-8, requires the commissioner of insurance to adopt rules defining "comparable coverage" in a manner that is consistent with federal law. For consistency of terms between state and federal laws, the revised law substitutes "comparable health coverage" for "comparable coverage" because that is the term used in 42 U.S.C. Section 1396g-1 (providing a list of the state-required medical child support laws). Appropriate changes have been made throughout this chapter.

Revised Law

Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE TO INJURED PERSON. A health benefit plan issuer that violates this chapter is subject to the same penalties, and an injured person has the same rights and remedies, as those provided by Subchapter D, Chapter 541. (V.T.I.C. Art. 3.96-9.)

Source Law

Art. 3.96-9. An insurer that violates this subchapter is subject to the same penalties, and an injured party has the same rights and remedies, as those provided by Section 16, Article 21.21, of this

code.

[Sections 1504.004-1504.050 reserved for expansion]

SUBCHAPTER B. DUTIES OF HEALTH BENEFIT PLAN ISSUER

Revised Law

Sec. 1504.051. ENROLLMENT OF CERTAIN CHILDREN REQUIRED. (a) A health benefit plan issuer shall permit a parent to enroll a child in dependent health coverage offered through the issuer regardless of any enrollment period restriction if the parent is:

(1) eligible for dependent health coverage; and

(2) required by a court order or administrative order to provide health insurance coverage for the child.

(b) A health benefit plan issuer shall enroll a child of a parent described by Subsection (a) in dependent health coverage offered through the issuer if:

(1) the parent does not apply to obtain health coverage for the child through the issuer; and

(2) the child, a custodial parent of the child, or a child support agency having a duty to collect or enforce support for the child applies for the coverage. (V.T.I.C. Art. 3.96-3.)

Source Law

> Art. 3.96-3. (a) If a parent eligible for dependent health coverage through an insurer is required by a court or administrative order to provide health coverage for a child, the insurer shall permit the parent to enroll the child without regard to any enrollment period restriction.
>
> (b) If a parent eligible for dependent health coverage through an insurer is required by a court or administrative order to provide health coverage for a child and fails to apply to obtain the health insurance coverage for the child, the insurer shall enroll the child on application of a custodial parent of the child, a child support agency having a duty to collect or enforce support for the child, or the child.

Revised Law

Sec. 1504.052. CHILD RESIDING OUTSIDE SERVICE AREA; COMPARABLE HEALTH COVERAGE REQUIRED. (a) A health benefit plan issuer may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child does not reside in the issuer's service area.

(b) A health benefit plan issuer may not enforce an otherwise applicable provision of the health coverage that would deny, limit, or reduce payment of a claim for a covered child who resides outside the issuer's service area but inside the United States.

(c) For a covered child who resides outside the health benefit plan issuer's service area and whose coverage under a policy or plan is required by a medical support order, the issuer shall provide coverage that is comparable health coverage to that provided to other dependents under the policy or plan.

(d) Comparable health coverage may include coverage in which a health benefit plan issuer uses different procedures for service delivery and health care provider reimbursement. Comparable health coverage may not include coverage:

(1) that is limited to emergency services only; or

(2) for which the issuer charges a higher premium.

(V.T.I.C. Art. 3.96-2 (part); Art. 3.96-8, Secs. (a), (b).)

Source Law

> Art. 3.96-2. An insurer may not deny enrollment of a child under the health insurance coverage of the child's parent on the ground that the child:
>
> . . .
>
> (4) does not reside . . . in the insurer's service area; or . . . .
>
> Art. 3.96-8. (a) An insurer shall provide coverage for a covered child who resides outside the insurer's service area, and whose coverage under a policy or plan is required by a medical support order, that is comparable coverage to that provided to other dependents under the policy or plan. In this subsection, "comparable coverage" may include coverage under which an insurer uses different procedures for service delivery and health care provider reimbursement. The coverage may not be limited to emergency services only. The coverage may not include coverage for which the insurer charges a higher premium.
>
> (b) An insurer may not enforce otherwise applicable provisions that would deny, limit, or reduce payment for claims for a covered child who lives outside the insurer's coverage territory but inside the United States.

Revisor's Note

Section (b), V.T.I.C. Article 3.96-8, refers to a health benefit plan issuer's "coverage territory."

The revised law substitutes "service area" for "coverage territory" for consistency of terms in this chapter.

Revised Law

Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE FOR CERTAIN CHILDREN. (a) A health benefit plan issuer may not cancel or refuse to renew health coverage provided to a child who is enrolled or entitled to enrollment under this chapter unless satisfactory written evidence is filed with the issuer showing that:

(1) the court or administrative order that required the coverage is not in effect; or

(2) the child:

(A) is enrolled in comparable health coverage; or

(B) will be enrolled in comparable health coverage that takes effect not later than the effective date of the cancellation or nonrenewal.

(b) For purposes of this section, a child is not enrolled or entitled to enrollment under this chapter if the child's eligibility for health coverage ends because the parent ceases to be eligible for dependent health coverage. (V.T.I.C. Art. 3.96-4.)

Source Law

> Art. 3.96-4. (a) An insurer may not cancel or refuse to renew insurance coverage of a child entitled to enrollment or enrolled under this subchapter unless satisfactory written evidence is filed with the insurer that shows that:
>
> (1) the court order or administrative order that required the coverage is no longer in effect; or
>
> (2) the child is enrolled in comparable health insurance coverage or will be enrolled in comparable coverage that will take effect not later than the effective date of the cancellation or nonrenewal.
>
> (b) As used in this section, "a child entitled to enrollment or enrolled under this subchapter" does not include a child whose eligibility has terminated because the parent eligible for dependent health coverage is no longer eligible for such coverage.

Revised Law

Sec. 1504.054. CONTINUATION OR CONVERSION OF COVERAGE. (a)

If a child's eligibility for dependent health coverage ends because the parent ceases to be eligible for the coverage and the coverage provides for the continuation or conversion of the coverage for the child, the health benefit plan issuer shall notify the custodial parent and the child support agency of the costs and other requirements for continuing or converting the coverage.

(b) The health benefit plan issuer shall, on application of a parent of the child, a child support agency, or the child, enroll or continue enrollment of a child whose eligibility for coverage ended under Subsection (a). (V.T.I.C. Art. 3.96-5.)

Source Law

> Art. 3.96-5. If dependent health coverage being terminated pursuant to Subsection (b), Article 3.96-4, of this code contains provisions for the continuation or conversion of such coverage for the child, the insurer shall notify the custodial parent and the child support agency of the costs and other requirements for extending or converting such coverage, and shall enroll or continue enrollment of the child on application of a parent of the child, a child support agency, or the child.

Revisor's Note

V.T.I.C. Article 3.96-5 refers to requirements for "extending or converting" health insurance coverage. The revised law substitutes "continuing" for "extending" for consistency of terms in this section.

Revised Law

Sec. 1504.055. PROCEDURE FOR CLAIMS. (a) A health benefit plan issuer that provides health coverage to a child through a covered parent of the child shall:

(1) provide to each custodial parent of the child or to an adult child documents and other information necessary for the child to obtain benefits under the coverage, including:

(A) the name of the issuer;

(B) the number of the policy or evidence of coverage;

(C) a copy of the policy or evidence of coverage

and schedule of benefits;

(D) a health coverage membership card;

(E) claim forms; and

(F) any other document or information necessary to submit a claim in accordance with the issuer's policies and procedures;

(2) permit a custodial parent, health care provider, state agency that has been assigned medical support rights, or adult child to submit claims for covered services without the approval of the covered parent; and

(3) make payments on covered claims submitted in accordance with this subsection directly to a custodial parent, health care provider, adult child, or state agency making a claim.

(b) A health benefit plan issuer shall provide to a state agency that provides medical assistance to the child or shall provide to a child support agency that enforces medical support on behalf of a child the information necessary to obtain reimbursement of medical services provided to or paid on behalf of the child. (V.T.I.C. Art. 3.96-6, Sec. (b); Art. 3.96-7.)

Source Law

[Art. 3.96-6]

(b) An insurer shall provide to a state agency providing medical assistance, or to a child support agency enforcing medical support, information as necessary to facilitate reimbursement of medical services provided to or paid on behalf of a child.

Art. 3.96-7. (a) If a child receives health insurance coverage through the insurer of a parent of the child, that insurer must provide information and documents to each custodial parent or an adult child as necessary for the child to obtain benefits through that coverage, including:

(1) the name of the insurer;

(2) the number of the policy;

(3) a copy of the policy and schedule of benefits;

(4) a health insurance membership card;

(5) claim forms; and

(6) any other information or document necessary to submit a claim in accordance with the insurer's policies and procedures.

(b) The insurer shall permit a custodial parent, a health care provider, adult child, or a state agency that has been assigned medical support rights to submit claims for covered services without the approval of the insured parent.

(c) The insurer shall make payments on covered

claims submitted in accordance with this article directly to the custodial parent, health care provider, adult child, or state agency making the claim.

Revisor's Note

(1) Sections (a)(2) and (3), V.T.I.C. Article 3.96-7, refer to a "policy" in the context of providing health coverage by a health benefit plan issuer. In this chapter, "health benefit plan issuer" is defined to include entities such as health maintenance organizations. These entities generally do not provide coverage through documents called "policies." Consequently, the revised law adds a reference to "evidence of coverage" because that is the name of the document issued by a health maintenance organization.

(2) Section (a)(4), V.T.I.C. Article 3.96-7, requires a health benefit plan issuer that provides health coverage to provide a "health insurance membership card." The revised law substitutes "health coverage membership card" for the reason stated in the revisor's note to Section 1504.001.

[Sections 1504.056-1504.100 reserved for expansion]

SUBCHAPTER C. PROHIBITED CONDUCT

Revised Law

Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS PROHIBITED. A health benefit plan issuer may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child:

(1) has a preexisting condition;

(2) was born out of wedlock;

(3) is not claimed as a dependent on the parent's federal income tax return;

(4) does not reside with the parent; or

(5) receives or has applied for medical assistance. (V.T.I.C. Art. 3.96-2 (part).)

Source Law

> Art. 3.96-2. An insurer may not deny enrollment of a child under the health insurance coverage of the child's parent on the ground that the child:
>
> (1) has a preexisting condition;
>
> (2) was born out of wedlock;
>
> (3) is not claimed as a dependent on the parent's federal income tax return;
>
> (4) does not reside with the parent or . . .
>
> (5) is or has been an applicant for or recipient of medical assistance.

Revised Law

Sec. 1504.102. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS: DIFFERENT REQUIREMENTS PROHIBITED. A health benefit plan issuer may not require a state agency that has been assigned the rights of an individual who is eligible for medical assistance and is covered for health benefits from the issuer to comply with a requirement that is different from a requirement imposed on an agent or assignee of any other covered individual. (V.T.I.C. Art. 3.96-6, Sec. (a).)

Source Law

> Art. 3.96-6. (a) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance and covered for health benefits from the insurer that are different from the requirements applicable to an agent or assignee of any other covered individual.

CHAPTER 1505. GROUP INSURANCE PLANS FOR PERSONS 65 YEARS OF AGE OR OLDER

CHAPTER 1505. GROUP HEALTH INSURANCE PLANS FOR PERSONS 65 YEARS OF AGE OR OLDER

Revised Law

Sec. 1505.001. DEFINITION. In this chapter, "health insurer" means an insurance company authorized to provide a hospital, surgical, and medical expense insurance plan in this state, including:

(1) a stock insurance company;

(2) a reciprocal or interinsurance exchange;

(3) a Lloyd's plan;

(4) a fraternal benefit society;

(5) a stipulated premium company; and

(6) a mutual insurance company, including a statewide mutual assessment company or a local mutual aid association. (V.T.I.C. Art. 3.71, Sec. 1 (part).)

Source Law

> Sec. 1. . . . insurance companies authorized to [separately] do such an insurance business in this state, including stock companies, reciprocals, or inter-insurance exchanges, Lloyds' associations, fraternal benefit societies and mutual companies of all kinds, including state-wide mutual assessment corporations and local mutual aid associations, and stipulated premium companies, [may join together to offer, sell and administer] hospital, surgical and medical expense insurance plans . . . .

Revised Law

Sec. 1505.002. PLANS FOR CERTAIN PERSONS 65 YEARS OF AGE OR OLDER. (a) Two or more health insurers may provide a hospital, surgical, and medical expense insurance plan under a group insurance policy that covers residents of this state who are at least 65 years of age and the spouses of those residents.

(b) The participating health insurers may enter into agreements regarding matters within the scope of this chapter, including:

(1) premium rates;

(2) policy provisions; and

(3) sales, administrative, technical, and accounting

procedures.

(c) Each participating health insurer is subject to regulation under the laws of this state and is severally liable on a group insurance policy issued under this chapter. (V.T.I.C. Art. 3.71, Secs. 1 (part), 2 (part).)

Source Law

> Art. 3.71
> Sec. 1. Notwithstanding any contrary or inconsistent provision of any law, two or more [insurance companies authorized to] separately [do such an insurance business in this state,] . . . may join together to offer, sell and administer hospital, surgical and medical expense insurance plans under a group policy covering residents of this state who are sixty-five (65) years of age and older and their spouses on which policy each insurance carrier shall be severally liable, and such companies may agree with respect to premium rates, policy provisions, sales, administrative, technical and accounting procedures and other matters within the scope of this Article. . . .
> Sec. 2. The insurance companies participating in the insurance plans authorized by this Article shall be subject to regulation under the laws of this state, and . . . .

Revisor's Note

Section 1, V.T.I.C. Article 3.71, refers to an authorization to engage in the business of insurance "[n]otwithstanding any contrary or inconsistent provision of any law." The revised law omits the quoted statement. The revised law is sufficient and specific authority for a health insurer to act as specified, and it is unnecessary to refer to other, more general provisions to which the revised law acts as an exception.

Revised Law

Sec. 1505.003. APPLICATION AND OTHER EVIDENCE OF INSURANCE FORMS. An application, policy, certificate, or other evidence of insurance form for an insurance plan under this chapter is subject to Chapter 1701. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

Source Law

> Sec. 2. . . . the forms of the applications, certificates, policies and other evidence of such insurance shall be subject to the requirements of

Article 3.42 of this Insurance Code. . . .

Revised Law

Sec. 1505.004. EXECUTION OF POLICY. An authorized person may execute an insurance policy subject to this chapter on behalf of the participating health insurers. (V.T.I.C. Art. 3.71, Sec. 1 (part).)

Source Law

> Sec. 1. . . . Any such policy may be executed on behalf of the insurance companies by a duly authorized person and . . . .

Revisor's Note

Section 1, V.T.I.C. Article 3.71, provides in part that a group insurance policy issued under that article is not required to be countersigned on behalf of a participating insurer by a resident agent, thus acting as an exception to the general requirement, established under former V.T.I.C. Article 21.09, that a resident agent countersign certain health insurance policies on behalf of the issuing insurer. The revised law omits this provision as unnecessary. V.T.I.C. Article 21.09 was repealed by the 75th Legislature in 1997, and there are no remaining countersignature requirements for group health insurance policies. The omitted law reads:

> Sec. 1 . . . [Any such policy may be executed on behalf of the insurance companies by a duly authorized person and] need not be countersigned on behalf of any such company by a resident agent. . . .

Revised Law

Sec. 1505.005. USE OF UNINCORPORATED ENTITY. (a) The participating health insurers may issue the group insurance policy in their own names or in the name of an unincorporated association, trust, or other organization formed for the sole purposes of this chapter and evidenced by a written contract executed by the insurers. An unincorporated association, trust, or other organization formed under this subsection may sue and be sued in the

name of the association, trust, or organization.

(b) A person licensed as a general life, accident, and health agent or as a general property and casualty agent under Chapter 4051 or 4054 may act in the licensed capacity in connection with an insurance policy or a certificate of insurance issued by an unincorporated association, trust, or other organization formed under Subsection (a). The agent is not required to notify the department that the person has been appointed to act for that purpose. (V.T.I.C. Art. 3.71, Secs. 1 (part), 3.)

Source Law

> Sec. 1. . . . Such companies may issue such insurance policies in their own names or in the name of an unincorporated association, trust, or other organization formed for the sole purposes of this Article and evidenced by a contract in writing executed by the participating insurance companies, and . . . . Any person who is licensed as a general life, accident, and health agent or as a general property and casualty agent under Article 21.07-1 or 21.14 of this code may act as such agent in connection with policies of insurance or certificates of insurance issued by any unincorporated association, trust or other organization formed for the sole purposes of this Article without the necessity of notifying the department that such person is appointed to so act.
>
> Sec. 3. Any unincorporated association, trust or other organization formed under the authority of this Article may sue and be sued in its association, trust or organization name.

Revisor's Note

Section 1, V.T.I.C. Article 3.71, validated certain contracts that established unincorporated associations, trusts, or other organizations to provide the coverage authorized under V.T.I.C. Article 3.71 and that were entered into before the effective date of that article. The revised law omits this provision as executed because the provision served its purpose on the day it took effect. Section 311.031(a)(2), Government Code (Code Construction Act), provides that the repeal of a statute does not affect any validation previously made under the statute. That section applies to the revised law. The

omitted law reads:

> Sec. 1. . . . any unincorporated associations, trusts, or other organizations heretofore formed for the sole purpose of this Article and evidenced by a contract in writing executed by the participating insurance companies is hereby ratified, confirmed and approved and validated from the date of its formation. . . .

Revised Law

Sec. 1505.006. REQUIRED FILINGS; DEPARTMENT APPROVAL. (a) The participating health insurers shall provide for the filing with the department on behalf of the insurers of:

(1) a copy of any contract of association or organization or trust agreement entered into by the insurers under this chapter;

(2) the schedule of premium rates to be charged for the insurance coverage; and

(3) the plan for operating and marketing the insurance.

(b) Except as provided by Subsection (c), a contract, schedule, or plan described by Subsection (a) may not be effective until approved by the commissioner.

(c) A contract, schedule, or plan described by Subsection (a) that is not approved or disapproved in a written order of the commissioner on or before the 30th day after the date on which the document is filed with the department is considered approved on the 31st day after the date of filing. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

Source Law

> Sec. 2. . . . There shall be filed with the State Board of Insurance by or on behalf of such companies a true copy of any contract of association or organization or trust agreement entered into by such companies pursuant to this Article, the schedule of premium rates to be charged for the insurance, and the plan for operating and marketing such insurance. No such contract, schedule or plan shall be effective unless and until approved by the State Board of Insurance, provided, however, that at the expiration of thirty days after the filing of any such contract, schedule or plan, it shall be deemed approved unless prior thereto it has been affirmatively approved or

disapproved by written order of said Board. . . .

Revisor's Note

(1) Section 2, V.T.I.C. Article 3.71, refers to the "State Board of Insurance." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished that board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the State Board of Insurance have been changed appropriately.

(2) Section 2, V.T.I.C. Article 3.71, refers to a "true copy" of a contract. The revised law omits "true" as unnecessary because the word does not add to the clear meaning of the law. For example, a document purporting to be a copy is not a copy if it is different from the original document.

Revised Law

Sec. 1505.007. EFFECT OF COMMISSIONER DISAPPROVAL. If, after notice and public hearing, the commissioner determines under reasonable assumptions that a premium rate charged for the insurance coverage offered under this chapter or the plan for operating and marketing that insurance is excessive, inadequate, or contrary to the public interest or that any activity or practice performed in connection with the insurance is unfair, unreasonable, or contrary to the public interest, the commissioner shall:

(1) enter an order containing the commissioner's determination and disapproving the premium rate or plan or the activity or practice; and

(2) require the discontinuance of the premium rate, plan, activity, or practice within a period that is not less than 30 days after the date of the commissioner's order containing the determination. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

Source Law

Sec. 2. . . . If after notice and public hearing the said Board shall at any time find that

under reasonable assumptions the premium rates charged for such insurance, or the plan for operating and marketing same are excessive, inadequate or contrary to the public interest, or that any activity or practice in connection with such insurance is unfair, unreasonable or contrary to the public interest, it shall disapprove such premium rates or plan or such activity or practice and shall require the discontinuance thereof within not less than thirty days from the date of its order containing such finding.

Revised Law

Sec. 1505.008. EXEMPTION FROM PREMIUM TAXES. Each premium received for group insurance coverage authorized by this chapter is exempt from any premium tax imposed by any other law of this state. (V.T.I.C. Art. 3.71, Sec. 4.)

Source Law

Sec. 4. Notwithstanding any contrary or inconsistent provision of any law of this state, all premiums received on account of the group insurance authorized by this Article are hereby expressly exempted and excluded from any and all premium taxes of any kind imposed by any other law of this state.

Revisor's Note

Section 4, V.T.I.C. Article 3.71, provides that certain premiums are exempt from premium taxes "[n]otwithstanding any contrary or inconsistent provision of any law of this state." The revised law omits the quoted provision for the reason stated in the revisor's note to Section 1505.002.

Revised Law

Sec. 1505.009. EXEMPTION FROM CERTAIN ANTITRUST REQUIREMENTS. An association, trust, or other organization formed and operated in accordance with this chapter or an insurance business conducted in accordance with this chapter is not considered a combination in restraint of trade, an illegal monopoly, or an attempt to lessen competition or fix prices arbitrarily and does not otherwise violate the antitrust laws of this state. (V.T.I.C. Art. 3.71, Sec. 5.)

Source Law

Sec. 5. No association, trust or other organization formed and operated in accordance with this Article and no insurance business conducted in

accordance with this Article shall be deemed to be a combination in restraint of trade, or an illegal monopoly, or an attempt to lessen competition or fix prices arbitrarily or to otherwise violate the anti-trust laws of this state.

CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1506.008-1506.050 reserved for expansion]

SUBCHAPTER B. BOARD OF DIRECTORS

[Sections 1506.059-1506.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF POOL

CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1506.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors of the pool.

(2) "Health benefit arrangement" means a plan, program, contract, or other arrangement through which an employer provides health care services, other than health care services covered through a health benefit plan issuer, to the employer's officers, employees, or other personnel.

(3) "Health benefit plan issuer" means an entity that provides health benefit plan coverage in this state, including stop-loss or excess loss insurance. The term includes:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization;

(F) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(G) an eligible surplus lines insurer operating under Chapter 981;

(H) an insurer providing stop-loss or excess loss insurance to physicians, health care providers, or hospitals or to any benefit arrangements to the extent permitted by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); and

(I) any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(4) "Health maintenance organization" means an entity that holds a certificate of authority to operate under Chapter 843.

(5) "Hospital" means a hospital for which a license is issued under Chapter 241, Health and Safety Code, or that is owned or operated by the federal or state government.

(6) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(7) "Pool" means the Texas Health Insurance Risk Pool.

(V.T.I.C. Art. 3.77, Secs. 2(2), (8), (9), (11), (12), (14), (16).)

Source Law

Sec. 2. In this article:

(2) "Board" means the board of directors of the pool.

(8) "Health maintenance organization" means a health maintenance organization that has a certificate of authority to operate in this state under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(9) "Hospital" means a licensed public or private institution as defined by Chapter 241, Health and Safety Code, and any hospital owned or operated by the federal or state government.

(11) "Insurer" means any entity that provides health insurance in this state, including stop-loss or excess loss insurance. For the purposes of this article, "insurer" includes but is not limited to an insurance company; a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); an approved nonprofit health corporation; a fraternal benefit society; a stipulated premium insurance company; a group hospital service corporation subject to Chapter 20 of this code; a surplus lines carrier; an insurer providing stop-loss or excess loss insurance to physicians, health care providers, hospitals, or to any benefit arrangements to the extent permitted by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(12) "Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an employer to its officers, employees, or other personnel but does not include health care services covered through an insurer.

(14) "Physician" means a person licensed to practice medicine in this state under the Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes).

(16) "Pool" means the Texas Health Insurance Risk Pool.

Revisor's Note

(1) Sections 2(3) and (4), V.T.I.C. Article 3.77, provide definitions of "commissioner" and "department." The revised law omits those definitions as unnecessary because Section 31.001 of this code contains definitions for those terms that are applicable throughout the code. The omitted law reads:

> (3) "Commissioner" means the commissioner of insurance.
>
> (4) "Department" means the Texas Department of Insurance.

(2) Section 2(10), V.T.I.C. Article 3.77, defines "insured" to mean a person who is "a resident of this state and a citizen of the United States and . . . eligible to receive benefits from the pool." Chapter 1084, Acts of the 77th Legislature, Regular Session, 2001, amended Section 10, V.T.I.C. Article 3.77, to allow certain individuals legally domiciled in this state to be eligible to receive benefits from the pool regardless of whether the individuals are citizens of the United States. The revised law omits the definition of "insured" because it conflicts with the clear intent of the amendment to Section 10 and thus was impliedly repealed. Also, the meaning of the term as used in the revised law is clear without a definition. The omitted law reads:

> (10) "Insured" means a person who is a resident of this state and a citizen of the United States and who is eligible to receive benefits from the pool. The term "insured" may include dependents and family members.

(3) Section 2(11), V.T.I.C. Article 3.77, provides a definition of "insurer" and Section 2(12), V.T.I.C. Article 3.77, provides a definition of "insurance arrangement." The revised law substitutes "health benefit plan issuer" for "insurer" because the

definition of "insurer" includes entities, such as health maintenance organizations, that provide health coverage but are not insurers. Consequently, "health benefit plan issuer" is a more accurate term. Likewise, the revised law substitutes "health benefit arrangement" for "insurance arrangement" because the definition of "insurance arrangement" refers to both insurance arrangements and other arrangements for health care services that are not insurance arrangements. The substitution of these terms, as well as related changes necessary to ensure consistency in terminology, is made throughout this chapter.

(4) Section 2(11), V.T.I.C. Article 3.77, provides that the defined term "includes but is not limited to" several types of entities. The phrase "but is not limited to" is omitted from the revised law as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, provide that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded. For clarity and consistency, the revised law also adds for four of the entities listed in Section 2(11) (an approved nonprofit health corporation, a fraternal benefit society, a stipulated premium company, and an eligible surplus lines insurer) references to the chapters of this code that provide the authority for the operation of each entity. The revised law substitutes "eligible surplus lines insurer" for "surplus lines carrier" for consistency with the terminology used in Chapter 981 of this code.

(5) Section 2(13), V.T.I.C. Article 3.77,

provides a definition of "Medicare." The revised law omits that definition as unnecessary because the term is commonly used in other statutes of the state without being defined, and its meaning is unambiguous. The omitted law reads:

> (13) "Medicare" means coverage provided by Part A and Part B, Title XVIII, Social Security Act (42 U.S.C. Section 1395c et seq.).

(6) Section 2(14), V.T.I.C. Article 3.77, refers to the Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). That statute was codified in 1999 as Subtitle B, Title 3, Occupations Code. The revised law is drafted accordingly.

Revised Law

Sec. 1506.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means an individual or group health benefit plan and includes:

(1) a hospital or medical expense incurred policy;

(2) coverage of medical or health care services offered by:

(A) a group hospital service corporation operating under Chapter 842;

(B) a fraternal benefit society operating under Chapter 885;

(C) a stipulated premium company operating under Chapter 884;

(D) a health maintenance organization;

(E) a multiple employer welfare arrangement subject to Chapter 846; or

(F) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; and

(3) any other health care plan or arrangement that pays for or furnishes medical or health care services by insurance or otherwise.

(b) In this chapter, "health benefit plan" does not include:

(1) short-term insurance;

(2) accident insurance;

(3) a plan providing coverage only for dental or vision care;

(4) fixed indemnity insurance, including hospital indemnity insurance;

(5) credit insurance;

(6) long-term care insurance;

(7) disability income insurance;

(8) other limited benefit coverage, including specified disease coverage;

(9) coverage issued as a supplement to liability insurance;

(10) insurance arising out of a workers' compensation or similar law;

(11) automobile medical payment insurance; or

(12) insurance coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance. (V.T.I.C. Art. 3.77, Sec. 2(7).)

Source Law

Sec. 2. In this article:

(7) "Health insurance" means individual or group health insurance and includes any hospital and medical expense incurred policy, a fraternal benefit society, a stipulated premium company, an approved nonprofit health corporation, health maintenance organization subscriber contract, coverage by a group hospital service plan, a multiple employer welfare arrangement subject to Subchapter I of this chapter, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. The term does not include short-term, accident, dental-only, vision-only, fixed indemnity, including hospital indemnity insurance, credit insurance, long-term care, disability income, or other limited benefit insurance, including specified disease insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault

and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Revisor's Note

(1) Section 2(7), V.T.I.C. Article 3.77, defines "health insurance" to include any "health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise." The revised law substitutes "health benefit plan" for "health insurance" throughout this chapter because the definition includes more than insurance, and the substituted term is more accurate. The revised law also makes related changes throughout this chapter as necessary to ensure consistency in terminology.

(2) Section 2(7), V.T.I.C. Article 3.77, lists several entities that provide health insurance. For clarity and consistency, the revised law adds for four of those entities (an approved nonprofit health corporation, a fraternal benefit society, a stipulated premium company, and a group hospital service corporation) references to the chapters of this code that provide the authority for the operation of each entity.

Revised Law

Sec. 1506.003. DEFINITION OF DEPENDENT. In this chapter, "dependent" means:

(1) a resident spouse or unmarried child younger than 25 years of age; or

(2) a child who is:

(A) a full-time student younger than 25 years of age who is financially dependent on the parent;

(B) 18 years of age or older and is an individual for whom a person may be obligated to pay child support; or

(C) disabled and dependent on the parent

regardless of the age of the child. (V.T.I.C. Art. 3.77, Sec. 2(5).)

Source Law

Sec. 2. In this article:

(5) "Dependent" means a resident spouse or unmarried child younger than 25 years of age, a child who is a full-time student younger than 25 years of age and who is financially dependent upon the parent, a child who is 18 years of age or older and for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent.

Revised Law

Sec. 1506.004. AUDIT OF POOL. (a) Annually, the state auditor shall conduct a special audit of the pool under Chapter 321, Government Code. The special audit must include a financial audit and an economy and efficiency audit.

(b) The state auditor shall report the cost of each audit conducted under this section to the board and the comptroller. The board shall remit that amount to the comptroller. (V.T.I.C. Art. 3.77, Sec. 15.)

Source Law

Sec. 15. (a) The state auditor shall conduct annually a special audit of the pool under Chapter 321, Government Code. The state auditor's report shall include a financial audit and an economy and efficiency audit.

(b) The state auditor shall report the cost of each audit conducted under this article to the board and the comptroller, and the board shall remit that amount to the comptroller for deposit to the general revenue fund.

Revisor's Note

Section 15(b), V.T.I.C. Article 3.77, requires money for the cost of an audit to be remitted to the comptroller "for deposit to the general revenue fund." The revised law omits the quoted provision as unnecessary. Section 404.094, Government Code, requires all money collected or received by a state agency, including the comptroller, to be deposited to the credit of the general revenue fund. It is unnecessary to repeat that requirement in this

chapter.

Revised Law

Sec. 1506.005. RULES. The commissioner may adopt rules necessary and proper to implement this chapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

Source Law

> Sec. 8. The commissioner . . . may adopt other rules as are necessary and proper to implement this article. . . .

Revised Law

Sec. 1506.006. COMPLAINT PROCEDURES. (a) An applicant for or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board.

(b) The grievance committee shall report to the board after completion of the review of each complaint.

(c) The board shall retain each written complaint concerning the pool at least until the third anniversary of the date the pool received the complaint. (V.T.I.C. Art. 3.77, Sec. 14.)

Source Law

> Sec. 14. An applicant or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board. The grievance committee shall report to the board after completion of the review of each complaint. The board shall retain all written complaints regarding the pool at least until the third anniversary of the date the pool received the complaint.

Revised Law

Sec. 1506.007. PROVISION OF INFORMATION ABOUT POOL. (a) A health benefit plan issuer may provide to its insureds and enrollees a notice relating to the existence of the pool that contains the address from which an insured or enrollee may obtain information about the coverage offered by the pool, the eligibility for and cost of the coverage, and other information that allows an insured or enrollee to compare the issuer's health benefit plan coverage provided to the insured or enrollee with the coverage offered by the pool.

(b) A health benefit plan issuer providing notice under this section shall provide the notice as prescribed by the commissioner.

(c) A health benefit plan issuer does not incur any liability solely for providing notice under this section. (V.T.I.C. Art. 3.77, Secs. 2(1), 16(a), (b) (part).)

Source Law

> Sec. 2. In this article:
>
> (1) "Benefits plan" means coverage to be offered by the pool to eligible persons under Section 11 of this article.
>
> Sec. 16. (a) An insurer may provide a notification to its insureds regarding the creation of the Texas Health Insurance Risk Pool and the address for information on cost, coverage, eligibility, and other information where an insured can compare his or her current health insurance with the benefits plan offered by the pool. The insurer shall not incur any liability solely for providing such notification.
>
> (b) An insurer providing notice under Subsection (a) shall provide such notice as prescribed by the commissioner. . . .

Revisor's Note

(1) Section 16(a), V.T.I.C. Article 3.77, refers to an "insured." The revised law adds a reference to an "enrollee" because this chapter applies to health maintenance organizations and similar entities. "Enrollee" is the proper term to refer to an individual covered under a benefit plan provided by a health maintenance organization.

(2) Section 16(b), V.T.I.C. Article 3.77, in the second sentence, provides authority for the commissioner to adopt rules to implement that section. The revised law omits that provision as unnecessary because Section 8 of Article 3.77, revised in relevant part as Section 1506.005, provides that authority for the entire article. The omitted law reads:

> (b) . . . The commissioner may promulgate rules to implement this section.

[Sections 1506.008-1506.050 reserved for expansion]

SUBCHAPTER B. BOARD OF DIRECTORS

Revised Law

Sec. 1506.051. GOVERNANCE OF POOL; BOARD MEMBERSHIP. (a) The pool is governed by a board of directors.

(b) The board consists of nine members appointed by the commissioner as follows:

(1) at least two, but not more than four, members must be individuals who are affiliated with a health benefit plan issuer authorized to write health benefit plans in this state;

(2) at least two of the members must be individuals or the parents of individuals who are covered by the pool or are reasonably expected to qualify for coverage by the pool; and

(3) the other members of the board may be selected from individuals such as:

(A) a physician licensed to practice in this state by the Texas State Board of Medical Examiners;

(B) a hospital administrator;

(C) an advanced nurse practitioner; or

(D) a representative of the public who is not:

(i) employed by or affiliated with an insurance company or insurance plan, group hospital service corporation, or health maintenance organization; or

(ii) licensed as, employed by, or affiliated with a physician, hospital, or other health care provider.

(c) For purposes of Subsection (b), an individual who is required to register under Chapter 305, Government Code, because of the individual's activities with respect to health benefit plan-related matters is affiliated with a health benefit plan issuer.

(d) An individual is not disqualified under Subsection (b)(3)(D)(i) from representing the public if the individual's only affiliation with an insurance company or insurance plan, group hospital service corporation, or health maintenance organization

is as an insured or as an individual who has coverage through a plan provided by the corporation or organization. (V.T.I.C. Art. 3.77, Secs. 4(a), (b) (part), (c), (d).)

Source Law

Sec. 4. (a) The pool is governed by a board of directors composed of nine members.

(b) The commissioner shall appoint members of the board . . . as provided by this section.

(c) The board shall be composed of:

(1) at least two persons affiliated with an insurer admitted and authorized to write health insurance in this state, but no more than four such persons;

(2) at least two persons who are insureds or parents of insureds or who are reasonably expected to qualify for coverage by the pool;

(3) the remaining members of the board may be selected from individuals such as a physician licensed to practice in this state by the Texas State Board of Medical Examiners, a hospital administrator, an advanced nurse practitioner, or representatives of the general public who are not employed by or affiliated with an insurance company or plan, group hospital service corporation, or health maintenance organization or licensed as or employed by or affiliated with a physician, hospital, or other health care provider. A representative of the general public does include a person whose only affiliation with an insurance company or plan, group hospital service corporation, or health maintenance organization is as an insured or person who has coverage through a plan provided by the corporation or organization.

(d) For purposes of this section, an individual required to register with the secretary of state under Chapter 305, Government Code, because of the individual's activities with respect to health insurance-related matters is a person affiliated with an insurer.

Revisor's Note

Section 4(d), V.T.I.C. Article 3.77, refers to an individual "required to register with the secretary of state under Chapter 305, Government Code." The revised law omits the reference to the secretary of state because under Chapter 304, Acts of the 72nd Legislature, Regular Session, 1991, an individual formerly required to register with the secretary of state must now register with the Texas Ethics Commission under Chapter 305, Government Code. A reference to the Texas Ethics Commission is unnecessary because Chapter 305, Government Code,

provides for registration only with that agency.

Revised Law

Sec. 1506.052. PRESIDING OFFICER. The commissioner shall designate one member of the board to serve as presiding officer at the pleasure of the commissioner. (V.T.I.C. Art. 3.77, Sec. 4(g).)

Source Law

> (g) The commissioner shall designate one of the commissioner's appointees to the board to serve as chairman. The chairman serves in that capacity at the pleasure of the commissioner.

Revisor's Note

Section 4(g), V.T.I.C. Article 3.77, refers to the "chairman" of the board. The revised law substitutes "presiding officer" for that term because, in context, the term has the same meaning, and "presiding officer" is more modern and is gender neutral.

Revised Law

Sec. 1506.053. TERMS; VACANCY. (a) Members of the board serve staggered six-year terms.

(b) The commissioner shall fill a vacancy on the board by appointing, for the unexpired term, an individual who has the appropriate qualifications to fill that position. (V.T.I.C. Art. 3.77, Secs. 4(b) (part), (e).)

Source Law

> (b) . . . for staggered six-year terms . . . .
>
> (e) If a vacancy occurs on the board, the commissioner shall fill the vacancy for the unexpired term with a person who has the appropriate qualifications to fill that position on the board.

Revised Law

Sec. 1506.054. PER DIEM; REIMBURSEMENT. A member of the board is entitled to:

(1) a per diem in the amount provided by the General Appropriations Act for state officials for each day the member performs duties as a board member; and

(2) reimbursement of expenses incurred while

performing duties as a board member in the amount provided by the General Appropriations Act for state officials. (V.T.I.C. Art. 3.77, Sec. 4(f).)

Source Law

> (f) Each member of the board is entitled to be paid a per diem for each day on which the member performs his duties as a member of the board and to reimbursement of his expenses while engaged in performing his duties as a member of the board. The amount of per diem and the amount of reimbursement for expenses is the same as provided by the General Appropriations Act for state officials.

Revised Law

Sec. 1506.055. MEMBER'S IMMUNITY. (a) A member of the board is not liable for an act or omission made in good faith in the performance of powers and duties under this chapter.

(b) A cause of action does not arise against a member of the board for an act or omission described by Subsection (a). (V.T.I.C. Art. 3.77, Sec. 4(h).)

Source Law

> (h) A member of the board of directors is not liable for an action or omission performed in good faith in the performance of powers and duties under this article, and cause of action does not arise against a member for the action or omission.

Revised Law

Sec. 1506.056. ADJUSTMENTS. (a) The board may adjust deductibles, the amounts of stop-loss coverage, and the periods governing preexisting conditions under Section 1506.155 to preserve the financial integrity of the pool.

(b) Not later than the 30th day after the date the board makes an adjustment under this section, the board shall submit to the commissioner a written report containing a description of and the reasons for the adjustment. (V.T.I.C. Art. 3.77, Sec. 11(c).)

Source Law

> (c) The board may adjust deductibles, the amounts of stop-loss coverage, and the time periods governing preexisting conditions under Section 12 of this article to preserve the financial integrity of the pool. If the board makes such an adjustment it shall report in writing that adjustment together with its reasons for the adjustment to the commissioner. The report must be submitted not later than the 30th

day after the date the adjustment is made.

Revised Law

Sec. 1506.057. ANNUAL REPORT OF POOL'S ACTIVITIES. (a) Not later than June 1 of each year, the board shall submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the commissioner.

(b) The report must summarize the activities of the pool in the calendar year preceding the year in which the report is submitted and must include information relating to net written and earned premiums, plan enrollment, administration expenses, and paid and incurred losses. (V.T.I.C. Art. 3.77, Sec. 6(d).)

Source Law

> (d) Not later than June 1 of each year, the board shall make an annual report to the governor, the lieutenant governor, the speaker of the house of representatives, and the commissioner. The report shall summarize the activities of the pool in the preceding calendar year, including information regarding net written and earned premiums, plan enrollment, administration expenses, and paid and incurred losses.

Revisor's Note

Section 6(d), V.T.I.C. Article 3.77, refers to an "annual report" and requires that it be filed not later than "June 1 of each year." The revised law omits "annual" as unnecessary because the law requires the report to be submitted each year and describes the period to be covered by the report.

Revised Law

Sec. 1506.058. ADDITIONAL POWERS AND DUTIES. The commissioner by rule may establish powers and duties of the board in addition to those provided by this chapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

Source Law

> Sec. 8. The commissioner may by rule establish additional powers and duties of the board and . . . .

Revisor's Note
(End of Subchapter)

The revised law omits Section 3, V.T.I.C. Article

3.77, relating to the creation of the Texas Health Insurance Risk Pool, as executed. The omitted law reads:

> Sec. 3. The Texas Health Insurance Risk Pool is created.

[Sections 1506.059-1506.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF POOL

Revised Law

Sec. 1506.101. PURPOSES OF POOL. (a) The purposes of the pool are to:

(1) provide for access to quality health care at minimum cost to the public;

(2) relieve the insurable population of the disruptive cost of sharing coverage; and

(3) maximize reliance on strategies of managed care proven by the private sector.

(b) The pool is not intended to diminish the availability of traditional health care coverage to consumers who are eligible for that coverage. (V.T.I.C. Art. 3.77, Secs. 1(c), (d).)

Source Law

> (c) To provide for access to quality health care at minimum cost to the public, to relieve the insurable population of the disruptive cost of sharing coverage, and to maximize reliance on strategies of managed care proven by the private sector, the legislature hereby authorizes the Texas Health Insurance Risk Pool.
>
> (d) The creation of the Texas Health Insurance Risk Pool is not intended to diminish the availability of traditional health care insurance to consumers who currently are eligible for these policies.

Revisor's Note

Sections 1(a) and (b), V.T.I.C. Article 3.77, contain legislative findings relating to the lack of availability of health insurance. The revised law omits the findings because they are executed. The omitted law reads:

> Art. 3.77
>
> Sec. 1. (a) The legislature finds that medically uninsurable Texans face critical problems with respect to health care coverage, access to care, job

mobility, and family impoverishment arising from their health status.

(b) Competitive forces in the marketplaces for health care and health insurance will operate over time to increase the number of medically uninsurable persons.

Revised Law

Sec. 1506.102. EMPLOYEES; COMMITTEES. (a) The pool may employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions.

(b) The pool may appoint appropriate legal, actuarial, and other committees necessary to provide technical assistance in operating the pool and performing any of the functions of the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(8) appoint appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in operating the pool and performing any of the functions of the pool;

(9) employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions;

. . .

Revised Law

Sec. 1506.103. PROVIDING COVERAGE. (a) The pool may provide health benefit coverage to an individual who is eligible for that coverage under this chapter.

(b) The pool may issue health benefit coverage subject to this chapter and the pool's plan of operation under Section 1506.201.

(c) The pool may issue additional types of health benefit coverage to provide optional coverages that comply with applicable provisions of state and federal law, including a Medicare supplement benefit plan. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

(1) provide health benefits coverage to persons who are eligible for that coverage under this article;

. . .

(7) issue insurance policies subject to this article and the plan of operation;

. . .

(13) issue additional types of health insurance policies to provide optional coverages which comply with applicable provisions of state and federal law, including Medicare supplemental health insurance;

. . .

Revisor's Note

Section 6(b)(13), V.T.I.C. Article 3.77, refers to "Medicare supplemental health insurance." The revised law substitutes "Medicare supplement benefit plan" because V.T.I.C. Article 3.77, revised as this chapter, applies to evidences of coverage issued by health maintenance organizations to supplement reimbursements under Medicare. Health maintenance organizations provide health benefit coverage, but the organizations are not insurers. Consequently, "benefit plan" is a more accurate term than "insurance." The substitution of "benefit plan" in this context, as well as any comparable change necessary to ensure consistency in terminology, is made throughout this chapter.

Revised Law

Sec. 1506.104. CHARGES, FORMULAS, AND FORMS. (a) The pool may establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, and claim reserve formulas and perform actuarial functions appropriate to the operation of the pool.

(b) The pool may adopt policy forms, endorsements, and riders and applications for coverage. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(5) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, and claim reserve formulas and perform any actuarial functions appropriate to the operation of the pool;

(6) adopt policy forms, endorsements, and riders and applications for coverage;

. . .

Revised Law

Sec. 1506.105. PREMIUM RATES. (a) The pool may not charge premium rates that are unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age, sex, and geographic location may apply for individual risks.

(c) Premium rates and premium rate schedules may be adjusted for appropriate risk factors, including age and variation in claim costs. The pool may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

(d) The pool shall establish the standard risk rate. In establishing the rate, the pool shall use reasonable actuarial techniques and consider the premium rates charged by other health benefit plan issuers offering health benefit coverage to individuals. The rate must reflect anticipated experience and expenses for health benefit coverage.

(e) Initial pool premium rates may not be less than 125 percent or greater than 150 percent of rates established as applicable for individual standard rates. Subsequent premium rates shall be established to provide fully for all of the expected costs of claims, including recovery of prior losses, expenses of operation, investment income from claim reserves, and any other cost factors, subject to the limitations described in this subsection. In no event may pool premium rates exceed 200 percent of rates applicable to individual standard risks.

(f) The pool shall submit each rate and rate schedule to the commissioner for approval. The pool may not use a rate or rate schedule before the rate or schedule is approved by the commissioner. In evaluating a rate or rate schedule of the pool, the commissioner shall consider the factors provided by this section. (V.T.I.C. Art. 3.77, Sec. 9.)

Source Law

Sec. 9. (a) Rates charged by the pool may not

be unreasonable in relation to the coverage provided and the risk experience and expenses of providing the coverage.

(b) Rates and rate schedules may be adjusted for appropriate risk factors including age and variation in claim costs, and the board may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

(c) Premiums charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age, sex, and geographic location may apply for individual risks.

(d) The pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for such coverage. Initial pool rates may not be less than 125 percent and may not exceed 150 percent of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection. In no event shall pool rates exceed 200 percent of rates applicable to individual standard risks.

(e) All rates and rate schedules shall be submitted to the commissioner for approval, and the commissioner must approve the rates and rate schedules of the pool before they are used by the pool. The commissioner in evaluating the rates and rate schedules of the pool shall consider the factors provided by this section.

Revised Law

Sec. 1506.106. REINSURANCE. The pool may provide for reinsurance on a facultative or treaty basis or on both facultative and treaty bases. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(16) provide for reinsurance on either a facultative or treaty basis or both.

Revised Law

Sec. 1506.107. CONTRACTS. (a) The pool may enter into a contract that is necessary to carry out this chapter, including, with the approval of the commissioner, a contract with:

(1) a similar pool in another state for the joint performance of common administrative functions; or

(2) another organization for the performance of

administrative functions.

(b) The pool may contract for stop-loss insurance for risks incurred by the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(2) enter into contracts that are necessary to carry out this article including, with the approval of the commissioner, entering into contracts with similar pools in other states for the joint performance of common administrative functions or with other organizations for the performance of administrative functions;

. . .

(10) contract for stop-loss insurance for risks incurred by the pool;

. . .

Revised Law

Sec. 1506.108. LEGAL ACTION. (a) The pool may sue or be sued.

(b) The pool may take any legal action necessary to:

(1) avoid payment of improper claims against the pool or the coverage provided by or through the pool; or

(2) recover or collect amounts due the pool, including:

(A) assessments due the pool;

(B) amounts erroneously or improperly paid by the pool; and

(C) amounts paid by the pool as a mistake of fact or law. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(3) sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the pool;

(4) institute any legal action necessary to avoid payment of improper claims against the pool or the coverage provided by or through the pool, to recover any amounts erroneously or improperly paid by the pool, to recover any amounts paid by the pool as a mistake of fact or law, and to recover other amounts due the pool;

. . .

Revised Law

Sec. 1506.109. COST CONTAINMENT. (a) The pool may provide

for and use cost containment measures and requirements, including preadmission screening, the requirement of a second surgical opinion, concurrent utilization review subject to Article 21.58A, and individual case management, to make the coverage offered by the pool more cost-effective.

(b) The pool may design, use, contract for, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations. (V.T.I.C. Art. 3.77, Secs. 2(1), 6(b) (part).)

Source Law

Sec. 2. In this article:

(1) "Benefits plan" means coverage to be offered by the pool to eligible persons under Section 11 of this article.

[Sec. 6]

(b) As part of its authority, the pool may:

. . .

(14) provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review subject to Article 21.58A of this code, and individual case management for the purpose of making the benefit plans more cost effective;

(15) design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations; and

. . .

Revisor's Note

Section 6(b)(14), V.T.I.C. Article 3.77, contains a list of cost containment measures, "including, but not limited to," certain specified items. The phrase "but not limited to" is omitted from the revised law for the reason stated in Revisor's Note (4) to Section 1506.001.

Revised Law

Sec. 1506.110. BORROWING. The pool may borrow money as necessary to implement the purposes of the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(12) borrow money as necessary to implement the purposes of the pool;

. . .

Revised Law

Sec. 1506.111. ADDITIONAL AUTHORITY. In addition to the other powers granted to the pool under this chapter, the pool may exercise any of the authority that a health benefit plan issuer authorized to write health benefit plans in this state may exercise under the law of this state. (V.T.I.C. Art. 3.77, Sec. 6(a).)

Source Law

Sec. 6. (a) The pool may exercise any of the authority that an insurance company authorized to write health insurance in this state may exercise under the law of this state.

[Sections 1506.112-1506.150 reserved for expansion]

SUBCHAPTER D. POOL COVERAGE AND BENEFITS

Revised Law

Sec. 1506.151. MINIMUM POOL COVERAGE. (a) The pool shall offer coverage consistent with major medical expense coverage to each eligible individual who is not eligible for Medicare.

(b) The board, with the approval of the commissioner, shall establish:

(1) the coverages to be provided by the pool;

(2) the applicable schedules of benefits; and

(3) any exclusions to coverage and other limitations.

(c) The benefits provisions of the pool's coverage must include:

(1) all required or applicable definitions;

(2) a description of covered services required under the pool;

(3) a list of any exclusions or limitations to coverage; and

(4) the deductibles, coinsurance options, and copayment options that are required or permitted. (V.T.I.C. Art. 3.77, Secs. 11(a), (b).)

Source Law

Sec. 11. (a) The pool shall offer pool coverage consistent with major medical expense coverage to each eligible person who is not eligible for Medicare. The board, with the approval of the commissioner, shall establish:

(1) the coverages to be provided by the pool;

(2) the applicable schedules of benefits; and

(3) any exclusions to coverage and other limitations.

(b) The benefits provisions of the pool's health benefits coverages must include the following:

(1) all required or applicable definitions;

(2) a list of any exclusions or limitations to coverage;

(3) a description of covered services required under the pool; and

(4) the deductibles, coinsurance options, and copayment options that are required or permitted under the pool.

Revised Law

Sec. 1506.152. ELIGIBILITY FOR COVERAGE. (a) An individual who is a legally domiciled resident of this state is eligible for coverage from the pool if the individual:

(1) provides to the pool evidence that the individual maintained health benefit plan coverage for the preceding 18 months with no gap in coverage longer than 63 days and with the most recent coverage being provided through an employer-sponsored plan, church plan, or government plan;

(2) provides to the pool evidence that the individual maintained health benefit plan coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because the individual did not reside in that state and submits an application for pool coverage not later than the 63rd day after the date the coverage described by this subdivision was terminated; or

(3) has been a legally domiciled resident of this state for the preceding 30 days, is a citizen of the United States or has been a permanent resident of the United States for at least three continuous years, and provides to the pool:

(A) a notice of rejection of, or refusal to

issue, substantially similar individual health benefit plan coverage from a health benefit plan issuer, other than an insurer that offers only stop-loss, excess loss, or reinsurance coverage, if the rejection or refusal was for health reasons;

(B) certification from an agent or salaried representative of a health benefit plan issuer that states that the agent or salaried representative cannot obtain substantially similar individual coverage for the individual from any health benefit plan issuer that the agent or salaried representative represents because, under the underwriting guidelines of the health benefit plan issuer, the individual will be denied coverage as a result of a medical condition of the individual;

(C) an offer to issue substantially similar individual coverage only with conditional riders;

(D) a notice of refusal by a health benefit plan issuer to issue substantially similar individual coverage except at a rate exceeding the pool rate; or

(E) a diagnosis of the individual with one of the medical or health conditions on the list adopted under Section 1506.154.

(b) Each dependent of an individual who is eligible for coverage from the pool is also eligible for coverage from the pool.

(c) If an individual who obtains coverage from the pool under Subsection (a) is a child, each parent, grandparent, brother, sister, or child of that individual who resides with that individual is also eligible for coverage from the pool.

(d) The board shall develop a form to be used for certification under Subsection (a)(3)(B). Before it may be used, the form must be approved by the commissioner. (V.T.I.C. Art. 3.77, Secs. 2(6), (17), 10(a), (b), (c).)

Source Law

[Sec. 2]

(6) "Family member" means a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

(17) "Resident" means:

(A) an individual who has been legally domiciled in Texas for a minimum of 30 days for persons eligible for enrollment in the pool under Section 10(b) of this article; or

(B) an individual who is legally domiciled in Texas for persons eligible for enrollment in the pool under Section 10(a) of this article.

Sec. 10. (a) An individual who is a resident, as defined by Section 2(17)(B) of this article, and who continues to be a resident, is eligible for coverage from the pool if the individual:

(1) provides to the pool evidence that the individual has maintained health insurance coverage for the previous 18 months, with no gap in coverage greater than 63 days, of which the most recent coverage was through an employer-sponsored plan, church plan, or government plan; or

(2) provides to the pool evidence that the individual had health insurance coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because the individual did not reside in that state and submits an application for pool coverage not later than the 63rd day after the date that coverage was terminated.

(b) Any individual who is and continues to be a resident, as defined by Section 2(17)(A) of this article, and who is a citizen of the United States or has been a permanent resident of the United States for at least three continuous years is eligible for coverage from the pool if the individual provides to the pool:

(1) a notice of rejection or refusal to issue substantially similar individual insurance for health reasons by one insurer, other than a rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage;

(2) a certification from an agent or salaried representative of an insurer, on a form developed by the board and approved by the commissioner, that states that the agent or salaried representative is unable to obtain substantially similar individual insurance for the individual with any state-licensed insurer that the agent or salaried representative represents because the individual will be declined for coverage as a result of a medical condition of the individual under the underwriting guidelines of the insurer;

(3) an offer to issue substantially similar individual insurance only with conditional riders;

(4) a refusal by an insurer to issue substantially similar individual insurance except at a rate exceeding the pool rate; or

(5) diagnosis of the individual with one of the medical or health conditions listed by the board under Section 6(c) of this article and for which a person shall be eligible for pool coverage.

(c) Each dependent of a person who is eligible for coverage from the pool shall also be eligible for coverage from the pool. In the instance of a child who is the primary insured, resident family members shall also be eligible for coverage.

Revisor's Note

(1) Section 10, V.T.I.C. Article 3.77, refers to an individual who is a resident and "continues to be a resident." The revised law omits the quoted language as unnecessary because an individual is a resident only as long as the individual continues to be a resident. Also, Section 10(f), V.T.I.C. Article 3.77, revised as Section 1506.158, expressly states that an individual's pool coverage generally ends on the date the individual ceases to be a resident.

(2) Section 10(b)(2), V.T.I.C. Article 3.77, refers to a "state-licensed insurer." "State-licensed insurer" refers to any foreign or domestic entity that has authority from the Texas Department of Insurance to engage in insurance business in this state and is equivalent to "insurer," as defined by Section 2(11), V.T.I.C. Article 3.77. The revised law substitutes "health benefit plan issuer" for "state-licensed insurer" for the reason stated in Revisor's Note (3) to Section 1506.001.

Revised Law

Sec. 1506.153. INELIGIBILITY FOR COVERAGE. Notwithstanding Section 1506.152, an individual is not eligible for coverage from the pool if:

(1) on the date pool coverage is to take effect, the individual has health benefit plan coverage from a health benefit plan issuer or health benefit arrangement in effect;

(2) at the time the individual applies to the pool, the individual is eligible for other health care benefits, including benefits from the continuation of coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.), as amended (COBRA), other than:

(A) coverage, including COBRA or other continuation coverage or conversion coverage, maintained for any

preexisting condition waiting period under a pool policy;

(B) employer group coverage conditioned by a limitation of the kind described by Section 1506.152(a)(3)(A) or (C); or

(C) individual coverage conditioned by a limitation described by Section 1506.152(a)(3)(C) or (D);

(3) within 12 months before the date the individual applies to the pool, the individual terminated coverage in the pool, unless the individual demonstrates a good faith reason for the termination;

(4) the individual is confined in a county jail or imprisoned in a state prison;

(5) any of the individual's premiums are paid for or reimbursed under a government-sponsored program or by a government agency or health care provider, other than as an otherwise qualifying full-time employee of a government agency or health care provider or as a dependent of such an employee;

(6) the individual's prior coverage with the pool was terminated:

(A) during the 12-month period preceding the date of application for nonpayment of premiums; or

(B) for fraud; or

(7) the individual is eligible for health benefit plan coverage provided in connection with a policy, plan, or program paid for or sponsored by an employer, even though the employer coverage is declined. (V.T.I.C. Art. 3.77, Secs. 10(e), (h) (part).)

Source Law

(e) A person is not eligible for coverage from the pool if the person:

(1) has in effect on the date pool coverage takes effect health insurance coverage from an insurer or insurance arrangement;

(2) is eligible for other health care benefits at the time application is made to the pool, including COBRA continuation, except:

(A) coverage, including COBRA continuation, other continuation or conversion coverage, maintained for the period of time the person

is satisfying any pre-existing condition waiting period under a pool policy; or

(B) employer group coverage conditioned by the type of limitations described by Subsections (b)(1) or (3) of this section; or

(C) individual coverage conditioned by the limitations described by Subsections (b)(3) or (4) of this section;

(3) has terminated coverage in the pool within 12 months of the date that application is made to the pool, unless the person demonstrates a good faith reason for the termination;

(4) is confined in a county jail or imprisoned in a state prison;

(5) has premiums that are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider;

(6) has had prior coverage with the pool terminated during the 12 months immediately preceding the date of application for nonpayment of premiums; or

(7) has had prior coverage with the pool terminated for fraud.

(h) A person who is eligible for health insurance benefits provided in connection with a policy, plan, or program paid for or sponsored by an employer, even though the employer coverage is declined, is not eligible for pool coverage. . . .

Revisor's Note

Section 10(e), V.T.I.C. Article 3.77, makes several references to COBRA continuation of health care coverage. While COBRA is an acronym that is used with some frequency, for clarity the revised law adds the name of the federal statute, the Consolidated Omnibus Budget Reconciliation Act of 1985, and its citation at the first reference to COBRA.

Revised Law

Sec. 1506.154. LIST OF COVERED CONDITIONS. (a) The board shall adopt a list of medical or health conditions for which an individual is eligible for pool coverage under Section 1506.152(a)(3)(E) without applying for health benefit plan coverage.

(b) The board may amend the list as appropriate. (V.T.I.C. Art. 3.77, Sec. 6(c) (part).)

Source Law

(c) The board shall promulgate a list of medical or health conditions for which a person shall be

eligible for pool coverage without applying for health insurance. The list . . . may be amended from time to time as may be appropriate.

Revisor's Note

(1) Section 6(c), V.T.I.C. Article 3.77, provides that the board may amend the list of conditions required by that section "from time to time." The revised law omits the quoted language as unnecessary because the power to take an action includes the power to act "from time to time."

(2) The part of Section 6(c), V.T.I.C. Article 3.77, that relates to the date on which the initial list of conditions became effective is omitted from the revised law as executed. The omitted law reads:

> (c) . . . [The list] shall be effective on the first day of the operation of the pool and . . . .

Revised Law

Sec. 1506.155. PREEXISTING CONDITIONS. (a) Except as provided by this section and Section 1506.056, pool coverage excludes charges or expenses incurred before the first anniversary of the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

(b) The exclusion provided by Subsection (a) does not apply to an individual who:

(1) was continuously covered for a period of at least 12 months, excluding any waiting period, by health benefit plan coverage that terminated not earlier than the 63rd day before the effective date of coverage under the pool; and

(2) applied for pool coverage not later than the 63rd day after the date the health benefit plan coverage described by Subdivision (1) terminated.

(c) If an individual was covered by health benefit plan coverage that was in effect at any time during the 12-month period

preceding the effective date of the individual's coverage under the pool, the pool shall subtract from the exclusion period required under Subsection (a) the period that the individual was covered under that health benefit plan and any waiting period that applied before that health benefit plan coverage became effective. (V.T.I.C. Art. 3.77, Sec. 12.)

Source Law

> Sec. 12. (a) Except as provided by this section and Section 11(c) of this article, pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.
>
> (b) A preexisting condition provision shall not apply to an individual who was continuously covered for an aggregate period of 12 months by health insurance that was in effect up to a date not more than 63 days before the effective date of coverage under the pool, excluding any waiting period, provided that the application for pool coverage is made no later than 63 days following the termination of coverage.
>
> (c) In determining whether a preexisting condition provision applies to an individual covered by the pool, the pool shall credit the time the individual was previously covered under health insurance if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the pool. Any waiting period that applied before that coverage became effective also shall be credited against the preexisting condition provision period.

Revised Law

Sec. 1506.156. BENEFIT REDUCTION. The pool shall reduce benefits otherwise payable under pool coverage by:

(1) the total amount paid or payable through any other health benefit plan or health benefit arrangement; and

(2) the total amount of hospital or medical expense benefits paid or payable under:

(A) workers' compensation coverage;

(B) automobile insurance, regardless of whether provided on the basis of fault or no fault; or

(C) a state or federal law or program. (V.T.I.C. Art. 3.77, Sec. 11(d).)

Source Law

(d) Benefits otherwise payable under pool coverage shall be reduced by amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile insurance whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

Revised Law

Sec. 1506.157. RECOVERY OF CERTAIN AMOUNTS. (a) The pool has a cause of action against an eligible individual for the recovery of the amount of benefits paid that are not for covered expenses.

(b) Benefits due from the pool may be reduced or refused as an offset against an amount recoverable under this section. (V.T.I.C. Art. 3.77, Sec. 11(e).)

Source Law

(e) The pool has a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the pool may be reduced or refused as an offset against any amount recoverable under this subsection.

Revised Law

Sec. 1506.158. TERMINATION OF POOL COVERAGE. (a) An individual's pool coverage ends:

(1) on the date the individual ceases to be a legally domiciled resident of this state, unless the individual:

(A) is a student younger than 25 years of age and is financially dependent on the parent;

(B) is a child for whom an individual may be obligated to pay child support; or

(C) is a child who is disabled and dependent on the parent, regardless of the age of the child;

(2) on the date the individual requests coverage to end;

(3) on the date the individual covered by the pool dies;

(4) on the date state law requires cancellation of the coverage;

(5) at the option of the pool, on the 31st day after the date the pool sends to the individual any inquiry concerning the individual's eligibility, including an inquiry concerning the individual's residence, to which the individual does not reply;

(6) on the 31st day after the date a premium payment for pool coverage becomes due if the payment is not made before that day; or

(7) at the time the individual ceases to meet the eligibility requirements for coverage.

(b) Notwithstanding Subsection (a), the coverage of an individual who ceases to meet the eligibility requirements for coverage terminates on the earlier of:

(1) the first premium due date after the date the pool determines the individual does not meet the eligibility requirements; or

(2) the first day of the first month after the month in which the pool determines the individual does not meet the eligibility requirements.

(c) The pool has the sole discretion to determine that an individual does not meet the eligibility requirements for coverage.

(d) An individual may maintain pool coverage for the period the individual is satisfying a preexisting waiting period under another health benefit plan or health benefit arrangement intended to replace the pool coverage. (V.T.I.C. Art. 3.77, Secs. 10(d), (f), (g).)

Source Law

(d) A person may maintain pool coverage for the period of time the person is satisfying a preexisting waiting period under another health insurance policy or insurance arrangement intended to replace the pool policy.

(f) Pool coverage shall cease:

(1) on the date a person is no longer a resident of this state, except for a child who is a student under 25 years of age and who is financially dependent upon the parent, a child for whom a person

may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent;

(2) on the date a person requests coverage to end;

(3) upon the death of the covered person;

(4) on the date state law requires cancellation of the policy;

(5) at the option of the pool, 30 days after the pool sends to the person any inquiry concerning the person's eligibility, including an inquiry concerning the person's residence, to which the person does not reply;

(6) on the 31st day after the day on which a premium payment for pool coverage becomes due if the payment is not made before that date; or

(7) at such time as the person ceases to meet the eligibility requirements of this section.

(g) Coverage of a person who ceases to meet the eligibility requirements of this section shall be terminated on the earlier of the premium due date that follows the date the pool determines the person does not meet the eligibility requirements or the first day of the month that follows the month in which the pool determines the person does not meet the eligibility requirements. The pool has the sole discretion to determine that a person does not meet the eligibility requirements.

Revisor's Note

Section 10(f)(1), V.T.I.C. Article 3.77, refers to a person who ceases to be "a resident of this state." Section 2(17), V.T.I.C. Article 3.77, provides the definition of "resident" for the purposes of that article, and that provision is revised in Section 1506.152. Under that provision, to qualify as a resident under V.T.I.C. Article 3.77 an individual must be legally domiciled in this state. The revised law in this section is drafted accordingly.

Revised Law

Sec. 1506.159. PROHIBITION ON ARRANGEMENT OR ATTEMPTED ARRANGEMENT OF CERTAIN POOL COVERAGE; PENALTY. (a) A health benefit plan issuer, agent, third-party administrator, or other person authorized or licensed under this code may not arrange or assist in, or attempt to arrange or assist in, the application for coverage from or placement in the pool of an individual who is not eligible under Section 1506.153(7) for coverage from the pool for the purpose of separating the person from health benefit plan coverage offered or provided in connection with employment that

would be available to the person as an employee or a dependent of an employee.

(b) A violation of this section is an unfair method of competition and an unfair or deceptive act or practice under Chapter 541. (V.T.I.C. Art. 3.77, Sec. 10(h) (part).)

Source Law

> (h) . . . An insurer, agent, third party administrator, or other person licensed under this code may not arrange or assist in or attempt to arrange or assist in the application for pool coverage by, or placement in the pool of a person who is ineligible under this subsection for the purpose of separating the person from health insurance benefits offered or provided in connection with employment that would be available to the person as an employee or dependent of an employee. A violation of this section is an unfair method of competition and an unfair or deceptive act or practice under Article 21.21 of this code.

Revisor's Note

Section 10(h), V.T.I.C. Article 3.77, refers to certain persons "licensed under this code." For consistency with other provisions of this code and because some of the persons listed would hold a certificate of authority under this code, the revised law refers to persons "authorized or licensed" under this code.

[Sections 1506.160-1506.200 reserved for expansion]

SUBCHAPTER E. OPERATION OF POOL

Revised Law

Sec. 1506.201. PLAN OF OPERATION. (a) Operation and management of the pool is governed by a plan of operation. The plan of operation includes the articles, bylaws, and operating rules of the pool that are adopted by the board.

(b) The plan of operation must ensure the fair, reasonable, and equitable administration of the pool.

(c) In addition to complying with the other requirements of this chapter, the plan of operation must include procedures for:

(1) operation of the pool;

(2) selection of an administrator as provided by

Section 1506.202;

(3) creation of a fund, under management of the board, for administrative expenses;

(4) handling, accounting, and auditing of money and other assets of the pool;

(5) development and implementation of a program to:

(A) publicize the existence of the pool, the eligibility requirements for coverage under the pool, and enrollment procedures; and

(B) foster public awareness of the pool;

(6) creation of a grievance committee to review complaints presented by applicants for coverage from the pool and individuals who are covered by the pool; and

(7) other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this chapter.

(d) The board shall amend the plan of operation as necessary to carry out this chapter. An amendment to the plan of operation must be approved by the commissioner before it becomes a part of the plan. (V.T.I.C. Art. 3.77, Secs. 2(15), 5(a) (part), (b), (f).)

Source Law

[Sec. 2]

(15) "Plan of operation" means the plan of operation of the pool and includes the articles, bylaws, and operating rules of the pool that are adopted by the board under Section 5 of this article.

Sec. 5. (a) . . . a plan of operation for the pool that will assure the fair, reasonable, and equitable administration of the pool.

(b) In addition to the other requirements of this article, the plan of operation must include procedures for:

(1) operation of the pool;

(2) selecting an administrator as provided under Section 7 of this article;

(3) creating a fund, under management of the board, for administrative expenses;

(4) handling, accounting, and auditing of money and other assets of the pool;

(5) developing and implementing a program to publicize the existence of the pool, the eligibility requirements for coverage under the pool, enrollment procedures, and to foster public awareness of the plan;

(6) creation of a grievance committee to

review complaints presented by applicants for coverage from the pool and insureds who receive coverage from the pool; and

(7) other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this article.

(f) The board shall amend the plan of operation as necessary to carry out this article. Amendments to the plan of operation must be approved by the commissioner before they become part of the plan.

Revisor's Note

Section 5(a), in part, and Sections 5(c), (d), and (e), V.T.I.C. Article 3.77, relate to the initial adoption of the plan of operation for the pool. Those provisions are omitted from the revised law as executed. The omitted law reads:

> Sec. 5. (a) The pool's initial board shall submit to the commissioner [a plan of operation for the pool] . . . .
>
> (c) After notice and hearing, the commissioner shall approve the plan of operation if it is determined that the plan is suitable to assure the fair, reasonable, and equitable administration of the pool.
>
> (d) The plan of operation takes effect on the date it is approved by commissioner order.
>
> (e) If the initial board fails to submit a suitable plan of operation before the 180th day following the appointment of the initial board, the commissioner, after notice and hearing, may adopt all necessary and reasonable rules to provide a plan for the pool. The rules adopted under this subsection shall continue in effect until the initial board submits, and the commissioner approves, a plan of operation under this section.

Revised Law

Sec. 1506.202. POOL ADMINISTRATOR. (a) The board may select one or more health benefit plan issuers or a third-party administrator authorized by the department to administer the pool. The selection must be made under a competitive bidding process in accordance with the plan of operation.

(b) The board shall establish criteria for evaluating the bids submitted under this section. The criteria must include:

(1) the bidder's proven ability to handle individual health benefit plans;

(2) the bidder's efficiency of claims paying procedures;

(3) an estimate of total charges for administering the pool;

(4) the bidder's ability to administer the pool in a cost-efficient manner; and

(5) the bidder's financial condition and stability. (V.T.I.C. Art. 3.77, Secs. 7(a), (b).)

Source Law

> Sec. 7. (a) After completing a competitive bidding process as provided by the plan of operation, the board may select one or more insurers or a third party administrator certified by the department to administer the pool.
>
> (b) The board shall establish criteria for evaluating the bids submitted. The criteria must include:
>
> (1) an insurer's or third party administrator's proven ability to handle individual accident and health insurance;
>
> (2) the efficiency of an insurer's or third party administrator's claims paying procedures;
>
> (3) an estimate of total charges for administering the pool;
>
> (4) an insurer's or third party administrator's ability to administer the pool in a cost-efficient manner; and
>
> (5) the financial condition and stability of the insurer or third party administrator.

Revisor's Note

> Section 7(a), V.T.I.C. Article 3.77, refers to certain persons "certified" to administer the pool. For consistency with other provisions of this code, the revised law substitutes "authorized" for "certified."

Revised Law

Sec. 1506.203. ADMINISTRATOR'S TERM; SUCCEEDING TERM. (a) A person selected as a pool administrator serves in that capacity for a three-year term beginning on the date the board issues its order making the selection.

(b) Not later than one year before the expiration of a pool administrator's term, the board shall invite all health benefit plan issuers, including the pool administrator, to submit bids to

serve as a pool administrator for the succeeding administration period. The selection of the succeeding pool administrator must be made not later than the sixth calendar month preceding the month in which the pool administrator's term expires. (V.T.I.C. Art. 3.77, Secs. 7(c), (d).)

Source Law

> (c) An insurer or third party administrator selected as an administering insurer or third party administrator to administer the pool under this section shall serve for a term of three years from the date on which the board issues its order formally making the selection.
>
> (d) Not later than one year before the expiration of an administering insurer's or third party administrator's term, the board shall invite all insurers, including the administering insurer or third party administrator, to submit bids to serve for the succeeding three-year administration period. Selection of the succeeding administering insurer or third party administrator must be made not later than the sixth calendar month preceding the month in which the administering insurer's or third party administrator's term expires.

Revised Law

Sec. 1506.204. ADMINISTRATOR'S FUNCTIONS. (a) A pool administrator shall perform the functions relating to the pool that are assigned to the administrator.

(b) The assigned functions may include:

(1) performing eligibility and administrative claims payment functions for the pool;

(2) establishing a billing procedure for collection of premiums from individuals covered by the pool;

(3) performing functions necessary to ensure timely payment of benefits to individuals covered by the pool, including:

(A) providing information relating to the proper manner of submitting a claim for benefits to the pool and distributing claim forms; and

(B) evaluating the eligibility of each claim for payment by the pool;

(4) submitting regular reports to the board relating to the operation of the pool; and

(5) determining after each calendar year the net

written and earned premiums, expenses of administration, and paid and incurred losses of the pool for that calendar year and reporting that information to the board and the commissioner.

(c) The board shall determine the form, content, and time of submission of the reports required under Subsection (b)(4).

(d) The commissioner shall prescribe the forms to be used to report the information under Subsection (b)(5).

(e) The board shall determine the times at which a pool administrator is to perform the billing functions for the pool. (V.T.I.C. Art. 3.77, Secs. 7(e), (g), (h).)

Source Law

> (e) The administering insurer or third party administrator shall perform such functions relating to the pool as may be assigned to it, including:
>
> (1) perform eligibility and administrative claims payment functions for the pool;
>
> (2) establish a billing procedure for collection of premiums from persons insured by the pool;
>
> (3) perform functions necessary to assure timely payment of benefits to persons covered under the pool, including:
>
> (A) providing information relating to the proper manner of submitting a claim for benefits to the pool and distributing claim forms; and
>
> (B) evaluating the eligibility of each claim for payment by the pool;
>
> (4) submit regular reports to the board relating to the operation of the pool; and
>
> (5) determine after the close of each calendar year the net written and earned premiums, expense of administration, and paid and incurred losses of the pool for that calendar year and report this information to the board and the commissioner on forms prescribed by the commissioner.
>
> (g) The board shall determine the form and content of the report required by Subsection (e)(4) of this section and the time at which reports must be made.
>
> (h) The board shall determine the times at which billing for the pool will be done by the administering insurer or third party administrator.

Revised Law

Sec. 1506.205. PAYMENTS TO ADMINISTRATOR. (a) The pool shall pay a pool administrator for the administrator's expenses incurred in performing duties and functions as provided by the plan of operation.

(b) Except as provided by Subsection (c), the total amount

of administrative costs and fees paid in a calendar year to all pool administrators may not exceed 12.5 percent of the gross premium receipts of the pool for the calendar year.

(c) The commissioner may approve payment of a higher amount, not to exceed 15 percent of the gross premium receipts of the pool for the calendar year, if the commissioner determines that the higher amount is necessary to pay the administrative costs and fees of the pool. (V.T.I.C. Art. 3.77, Sec. 7(f).)

Source Law

> (f) The pool shall pay an administering insurer or third party administrator for its expenses incurred in performing its .duties and functions as provided by the plan of operation. Except as otherwise provided by this subsection, the total amount of administrative costs and fees paid in a calendar year to all administering insurers or a third party administrator may not exceed 12.5 percent of the gross premium receipts of the pool for the calendar year. The commissioner may approve payment of a higher amount, not to exceed 15 percent of the gross premium receipts of the pool for the calendar year, if the commissioner determines that the higher amount is necessary to pay the administrative costs and fees of the pool.

[Sections 1506.206-1506.250 reserved for expansion]

SUBCHAPTER F. ASSESSMENTS FOR OPERATION OF POOL

Revised Law

Sec. 1506.251. INTERIM ASSESSMENTS. (a) The board may assess health benefit plan issuers, including making advance interim assessments, as reasonable and necessary for the pool's organizational and interim operating expenses.

(b) The board shall credit an interim assessment as an offset against any regular assessment that is due after the end of the fiscal year. (V.T.I.C. Art. 3.77, Sec. 13(a).)

Source Law

> Sec. 13. (a) The board may assess insurers and make advance interim assessments as reasonable and necessary for the plan's organizational and interim operating expenses. Any interim assessment shall be credited as offsets against any regular assessments due following the close of the fiscal year.

Revised Law

Sec. 1506.252. DETERMINATION OF NET LOSS. (a) After the end of each fiscal year, the board shall determine for the preceding

calendar year any net loss of the pool, including administrative expenses and incurred losses, and report the net loss to the commissioner.

(b) In determining the net loss, the board shall take into account investment income and other appropriate gains and losses. (V.T.I.C. Art. 3.77, Sec. 13(c) (part).)

Source Law

> (c) After the end of each fiscal year, the board shall determine and report to the commissioner the net loss, if any, of the pool for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses. . . .

Revised Law

Sec. 1506.253. ASSESSMENTS TO COVER NET LOSSES. (a) The board shall recover any net loss of the pool by assessing each health benefit plan issuer an amount determined annually by the board based on information in annual statements and other reports required by and filed with the board.

(b) The amount of a health benefit plan issuer's assessment is computed by multiplying the total amount required to be assessed against all health benefit plan issuers by a number computed by dividing:

(1) the gross premiums collected by the issuer for health benefit plans in this state during the preceding calendar year; by

(2) the gross premiums collected by all issuers for health benefit plans in this state during the preceding calendar year.

(c) For purposes of Subsection (b), gross health benefit plan premiums do not include Medicare supplement benefit plan premiums subject to Chapter 1652 or small employer health benefit plan premiums subject to Subchapters A-H, Chapter 1501. (V.T.I.C. Art. 3.77, Secs. 13(c) (part), (d) (part).)

Source Law

> (c) . . . Any net loss for the year shall be recouped by assessments on insurers. Each insurer's

assessment shall be determined annually by the board based on annual statements and other reports required by the board and filed with the board.

(d) The assessment imposed against each insurer shall be in an amount that is equal to the ratio of the gross premiums collected by the insurer for health insurance in this state during the preceding calendar year, except for Medicare supplement premiums subject to Article 3.74 and small group health insurance premiums subject to Articles 26.01 through 26.76, to the gross premiums collected by all insurers for health insurance, except for Medicare supplement premiums subject to Article 3.74 and small group health insurance premiums subject to Articles 26.01 through 26.76, in this state during the preceding calendar year. . . .

Revisor's Note

Section 13(d), V.T.I.C. Article 3.77, refers to "small group health insurance premiums subject to Articles 26.01 through 26.76." V.T.I.C. Chapter 26 refers to "small employer health benefit plans" rather than "small group health insurance," and the revised law is drafted accordingly.

Revised Law

Sec. 1506.254. ASSESSMENT DUE DATE; INTEREST. (a) An assessment is due on the date specified by the board that is not earlier than the 30th day after the date written notice of the assessment is transmitted to the health benefit plan issuer.

(b) Interest accrues on the unpaid amount of an assessment at a rate equal to the prime lending rate, as published in the most recent issue of the Wall Street Journal and determined as of the date the assessment becomes delinquent, plus three percent. (V.T.I.C. Art. 3.77, Sec. 13(d) (part).)

Source Law

(d) . . . An assessment is due on a date specified by the board that may not be earlier than the 30th day after the date on which prior written notice of the assessment due is transmitted to the insurer. Interest accrues on the unpaid amount at a rate equal to the prime lending rate, as stated in the most recent issue of the Wall Street Journal, plus three percent, determined as of the date such assessment is delinquent.

Revised Law

Sec. 1506.255. ABATEMENT OR DEFERMENT OF ASSESSMENT. (a) A health benefit plan issuer may petition the commissioner for an

abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the health benefit plan issuer to fulfill its contractual obligations.

(b) If all or part of an assessment against a health benefit plan issuer is abated or deferred, the amount of the abatement or deferment shall be assessed against the other health benefit plan issuers in a manner consistent with the method for computing assessments under this subchapter.

(c) A health benefit plan issuer receiving an abatement or deferment under this section remains liable to the pool for the deficiency. (V.T.I.C. Art. 3.77, Sec. 13(e).)

Source Law

> (e) An insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. If all or part of an assessment against an insurer is abated or deferred, the amount by which the assessment is abated or deferred shall be assessed against the other insurers in a manner consistent with the basis for computing assessments under this section. An insurer receiving an abatement or deferment under this subsection remains liable to the pool for the deficiency.

Revised Law

Sec. 1506.256. USE OF EXCESS FROM ASSESSMENTS. (a) In this section, "future losses" includes reserves for claims incurred but not reported.

(b) If the total amount of the assessments exceeds the pool's actual losses and administrative expenses, the board shall deposit the excess in an interest-bearing account and shall use money in that account to offset future losses or to reduce future assessments. (V.T.I.C. Art. 3.77, Sec. 13(b).)

Source Law

> (b) If assessments exceed the pool's actual losses and administrative expenses, the excess shall be held in an interest-bearing account and used by the board to offset future losses or to reduce future

assessments. As used in this section, future losses includes reserves for incurred but not reported claims.

Revised Law

Sec. 1506.257. COLLECTION OF ASSESSMENTS. The pool may recover or collect assessments made under this subchapter. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(11) recover or collect assessments imposed under Section 13 of this article;

. . .

Revised Law

Sec. 1506.258. PROCEDURES, CRITERIA, AND FORMS. The commissioner by rule shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments under this subchapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

Source Law

Sec. 8. . . . The commissioner by rule shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments made and collected under Section 13.

[Chapters 1507-1550 reserved for expansion]

SUBTITLE I. SPECIALIZED COVERAGES

CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1651.007-1651.050 reserved for expansion]

SUBCHAPTER B. BENEFIT PLAN STANDARDS

CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1651.001. APPLICABILITY OF CHAPTER. (a) Notwithstanding Section 101.053(b)(5) and subject to Subsection (b), this chapter applies only to:

(1) an individual long-term care benefit plan that is delivered or issued for delivery in this state;

(2) a group long-term care benefit plan that is:

(A) delivered or issued for delivery in this state; and

(B) issued to an eligible group as described by Subchapter B, Chapter 1251;

(3) a certificate issued under a group long-term care benefit plan issued to an eligible group as described by Subchapter B, Chapter 1251, if the certificate is delivered or issued for delivery in this state, regardless of the place where the plan is delivered or issued for delivery; and

(4) an evidence of coverage delivered or issued for delivery in this state for long-term care.

(b) This chapter applies only to a policy, certificate, or evidence of coverage that is issued by:

(1) a capital stock insurance company, including a life, health and accident, or general casualty insurance company;

(2) a mutual life insurance company;

(3) a mutual assessment life insurance company, including a statewide mutual assessment corporation, local mutual aid association, and burial association;

(4) a mutual or mutual assessment association, including an association subject to Section 887.101;

(5) a mutual insurance company other than a life insurance company;

(6) a mutual or natural premium life or casualty

insurance company;

(7) a fraternal benefit society;

(8) a Lloyd's plan insurer;

(9) a reciprocal or interinsurance exchange;

(10) a nonprofit medical, hospital, or dental service corporation, including a company subject to Chapter 842;

(11) a stipulated premium company;

(12) a health maintenance organization under Chapter 843; or

(13) another insurer required to be licensed by the department. (V.T.I.C. Art. 3.70-12, Secs. 1(a), (b), 2(2), (3).)

Source Law

Art. 3.70-12

Sec. 1. (a) Notwithstanding Section 2(b)(5) of Article 1.14-1 of this code, this article applies to and governs individual and group long-term care insurance policies delivered or issued for delivery in this state and certificates issued under group long-term care insurance policies that have been delivered or issued for delivery in this state, if those policies or certificates are issued by:

(1) capital stock companies, including but not limited to life, health and accident, and general casualty companies;

(2) mutual life insurance companies;

(3) mutual assessment life insurance companies, including statewide mutual assessment corporations, local mutual aids, and burial associations;

(4) mutual and mutual assessment associations of all kinds and types, including associations subject to Article 14.17 of this code;

(5) mutual insurance companies other than life companies;

(6) mutual or natural premium life or casualty insurance companies;

(7) fraternal benefit societies;

(8) Lloyd's plan insurers;

(9) reciprocal or inter-insurance exchanges;

(10) nonprofit hospital, medical or dental service corporations, including companies subject to Chapter 20 of this code;

(11) stipulated premium insurance companies; or

(12) any other insurer which by law is required to be licensed by the Texas Department of Insurance.

(b) This article shall apply to evidences of coverage delivered or issued for delivery for long-term care in this state by health maintenance organizations under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

Sec. 2. In this article:

(2) "Certificate" means any certificate issued under a group long-term insurance policy, which certificate has been delivered or issued for delivery in this state, regardless of the place where the policy was delivered or issued for delivery.

(3) "Group long-term care insurance" means any long-term care insurance policy or certificate of group long-term care insurance which is delivered or issued for delivery in this state and issued to an eligible group as defined by Section 1(a), Article 3.51-6 of this code.

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 3.70-12, states that this article "applies to and governs" certain long-term care insurance policies. The revised law omits "governs" because, in context, "governs" is included in the meaning of "applies to."

(2) Sections 1(a) and 2(2), V.T.I.C. Article 3.70-12, refer to long-term care "insurance policies," and Section 2(3), V.T.I.C. Article 3.70-12, defines group long-term care "insurance." The revised law substitutes "benefit plan" for the references to insurance policies and insurance because V.T.I.C. Article 3.70-12, revised as this chapter, applies to evidences of coverage for long-term care issued by health maintenance organizations. Health maintenance organizations provide health benefit coverage, but the organizations are not insurers. Consequently, "benefit plan" is a more accurate term than "insurance policy" or "insurance." The substitution of "benefit plan," as well as any comparable change necessary to ensure consistent terminology, is made throughout this chapter.

(3) Section 1(a)(1), V.T.I.C. Article 3.70-12, refers to "including but not limited to." "But not limited to" is omitted as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, provide that

"includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

Revised Law

Sec. 1651.002. EXEMPTIONS. This chapter does not apply to:

(1) a certificate that is delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state; or

(2) a benefit plan that is not advertised, marketed, or offered as a long-term care benefit plan or nursing home benefit plan. (V.T.I.C. Art. 3.70-12, Secs. 1(d), (e).)

Source Law

(d) This article does not apply to certificates that are delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state.

(e) This article does not apply to a policy that is not advertised, marketed, or offered as long-term care insurance or nursing home insurance.

Revised Law

Sec. 1651.003. LONG-TERM CARE BENEFIT PLAN DEFINED. (a) In this chapter, "long-term care benefit plan" means an insurance policy or group certificate, or rider to the policy or certificate, or evidence of coverage issued by a health maintenance organization subject to Chapter 843, that is advertised or marketed as providing, or offered or designed to provide, coverage for not less than 12 consecutive months for each covered individual on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital.

(b) The term includes a plan or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or the loss of

functional capacity.

(c) The term does not include an insurance policy, group certificate, or evidence of coverage that is offered primarily to provide:

(1) basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage; or

(2) basic or single health care services. (V.T.I.C. Art. 3.70-12, Sec. 2(4).)

Source Law

Sec. 2. In this article:

> (4) "Long-term care insurance policy" means any insurance policy, group certificate, or rider to such policy or certificate, or evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), which policy, certificate, rider or evidence of coverage is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term also includes a policy or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or the loss of functional capacity. The term "long-term care insurance" shall not include any insurance policy or group certificate which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, or basic or single health care services.

Revisor's Note

Section 2(4), V.T.I.C. Article 3.70-12, in the third sentence, excludes "any insurance policy or group certificate" from the scope of the defined term if the policy or certificate provides certain

specified coverage. The revised law adds a reference to "evidence of coverage" to the exclusionary language for clarity and consistency with the remainder of Section 2(4). The first sentence of Section 2(4) provides that "evidence of coverage" is included in the scope of the defined term in some instances. Consequently, in context, it is clear that "evidence of coverage" should be excluded in the instances described in the third sentence of Section 2(4).

Revised Law

Sec. 1651.004. RULES. (a) In addition to other rules required or authorized by this chapter, the department may adopt reasonable rules that are necessary and proper to carry out this chapter.

(b) Rules adopted under this section must include requirements no less favorable than the minimum standards for long-term care benefit plans adopted in any model laws or regulations relating to minimum standards for benefits for long-term care benefit plans and in accordance with all applicable federal law. (V.T.I.C. Art. 3.70-12, Sec. 7.)

Source Law

Sec. 7. In addition to other rules required or authorized by this article, the State Board of Insurance may adopt reasonable rules that are necessary and proper to carry out this article. Any rules so adopted shall include requirements no less favorable than minimum standards for long-term care insurance adopted in any model laws or regulations relating to minimum standards for benefits for long-term care insurance and in accordance with all applicable federal law.

Revisor's Note

Section 7, V.T.I.C. Article 3.70-12, refers to "the State Board of Insurance." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the

board have been changed appropriately.

Revised Law

Sec. 1651.005. CONSTRUCTION OF CHAPTER. This chapter may not be construed to enlarge the powers of an entity listed in Section 1651.001. (V.T.I.C. Art. 3.70-12, Sec. 1(c).)

Source Law

> (c) This article may not be construed to enlarge the powers of any of the enumerated companies.

Revised Law

Sec. 1651.006. CONFLICTS WITH OTHER PROVISIONS. This chapter prevails to the extent of any conflict with another provision of this code. (V.T.I.C. Art. 3.70-12, Sec. 6 (part).)

Source Law

> Sec. 6. . . . in the event of any conflict between a provision of this article and any other provisions of this code, the provision of this article controls to the extent of the conflict. . . .

Revisor's Note

(1) Section 6, V.T.I.C. Article 3.70-12, refers to the cumulative effect of that article. An accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless it provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. The omitted law reads:

> Sec. 6. This article is cumulative of all other law, but . . . .

(2) The portion of Section 6, V.T.I.C. Article 3.70-12, that provides that the article is severable is omitted because that provision duplicates Section 311.032, Government Code (Code Construction Act), applicable to the revised law, and Section 312.013, Government Code. These provisions state that a provision of a statute is severable from each other provision of the statute that can be given effect. The omitted law reads:

Sec. 6. . . . If any provision of this article or the application of any provision of this article to any person or circumstance is for any reason held to be invalid, the remainder of this article and the application of that provision to other persons or circumstances shall not be affected by the invalidity.

[Sections 1651.007-1651.050 reserved for expansion]

SUBCHAPTER B. BENEFIT PLAN STANDARDS

Revised Law

Sec. 1651.051. MINIMUM STANDARDS. (a) The commissioner by rule shall establish:

(1) specific standards for provisions of long-term care benefit plans; and

(2) standards for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of those benefit plans.

(b) The standards are in addition to and must be in accordance with:

(1) applicable laws of this state, including Chapter 1201;

(2) applicable federal law; and

(3) any rules, regulations, and standards required by federal law.

(c) The standards must address:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) coverage of dependents;

(5) coverage of parents of the insured or enrollee and parents of the spouse of the insured or enrollee;

(6) preexisting conditions;

(7) termination of insurance;

(8) continuation or conversion;

(9) probationary periods;

(10) benefit limitations, exceptions, and reductions;

(11) elimination periods;

(12) requirements for replacement;

(13) recurrent conditions;

(14) definitions of terms; and

(15) inflation protection.

(d) The standards may:

(1) establish standard claim forms;

(2) establish standard benefits for:

(A) skilled nursing care;

(B) intermediate nursing care;

(C) custodial care; and

(D) home health care;

(3) require coverage for skilled nursing care, intermediate nursing care, and custodial care to facilitate comparison among long-term care products;

(4) require long-term care benefit plan issuers to offer coverage for home health care benefits;

(5) require that rates may not be increased for a covered individual unless:

(A) the covered individual requests and receives a change of benefits; or

(B) the increase applies to all members of the class to which the individual has been assigned by the benefit plan issuer; or

(6) require a benefit plan issuer to pay for a service covered by the benefit plan that is provided by an institution licensed to provide that service under Chapter 242, Health and Safety Code.

(e) Rules adopted under this section must include requirements no less favorable than the minimum standards of benefits for long-term care benefit plans adopted in any model laws or regulations relating to minimum standards for benefits for long-term care benefit plans and required by federal law. (V.T.I.C. Art. 3.70-12, Secs. 3(a), (b), (c), (d).)

Source Law

Sec. 3. (a) The State Board of Insurance by rule shall establish specific standards for provisions of long-term care insurance policies and standards for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of long-term care insurance policies. Those standards are in addition to and in accordance with applicable laws of this state, including Subchapter G of Chapter 3 of this code, applicable federal law, and any rules, regulations, and standards required by federal law.

(b) The standards established under Subsection (a) of this section shall cover the following:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) coverage of dependents;

(5) coverage of parents of the insured and parents of the spouse of the insured;

(6) preexisting conditions;

(7) termination of insurance;

(8) continuation or conversion;

(9) probationary periods;

(10) benefit limitations, exceptions, and reductions;

(11) elimination periods;

(12) requirements for replacement;

(13) recurrent conditions;

(14) definitions of terms; and

(15) inflation protection.

(c) The standards established under Subsection (a) of this section may:

(1) establish standard claim forms;

(2) establish standard benefits for:

(A) skilled nursing care;

(B) intermediate nursing care;

(C) custodial care; and

(D) home health care;

(3) require coverage for skilled nursing care, intermediate nursing care, and custodial care to facilitate comparison among long-term care insurance products;

(4) require insurers to offer coverage for home health care benefits;

(5) require that premium rates may not be raised for a covered individual unless either the covered individual requests and receives a change of benefits or the increase is made for all members of the class to which the individual has been assigned by the insurer; or

(6) require an insurer to pay for services covered by the policy that are rendered by any institution licensed to provide those services under Chapter 242, Health and Safety Code.

(d) Any rules issued by the State Board of Insurance under this section shall include requirements no less favorable than the minimum standards of benefits for long-term care insurance adopted in any model laws or regulations relating to minimum standards for benefits for long-term care insurance and mandated by federal law.

Revisor's Note

(1) Section 3(a), V.T.I.C. Article 3.70-12,

refers to the "applicable laws of this state, including Subchapter G of Chapter 3" of the Insurance Code. The majority of Subchapter G, Chapter 3, Insurance Code, and the provisions primarily applicable to long-term care benefit plans, are revised as Chapter 1201 of this code. The revised law is drafted accordingly.

(2) Section 3(b)(5), V.T.I.C. Article 3.70-12, refers to "the insured." The revised law adds a reference to an "enrollee" because this chapter applies to a health maintenance organization that provides long-term care coverage. "Enrollee" is the proper term to refer to a person covered under a benefit plan provided by a health maintenance organization.

Revised Law

Sec. 1651.052. PREEXISTING CONDITIONS. (a) A long-term care benefit plan may not contain a provision that denies coverage for a claim for losses incurred more than six months after the effective date of coverage for a preexisting condition.

(b) A long-term care benefit plan may not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(c) The commissioner by rule may:

(1) establish additional reasonable regulation of preexisting conditions consistent with this section and Section 1651.051; and

(2) extend a limitation period specified in this section as to a specific age group category in a specific benefit plan form if the commissioner finds that the extension is in the best interest of the public.

(d) Rules adopted under this section must comply with

Section 1651.051(e). (V.T.I.C. Art. 3.70-12, Secs. 3(d), (e).)

Source Law

(d) Any rules issued by the State Board of Insurance under this section shall include requirements no less favorable than the minimum standards of benefits for long-term care insurance adopted in any model laws or regulations relating to minimum standards for benefits for long-term care insurance and mandated by federal law.

(e) In addition to other provisions of this section, a long-term care insurance policy or certificate subject to this article may not contain a provision which denies a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. A policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage. The State Board of Insurance by rule may provide for additional reasonable regulation of preexisting conditions consistent with this section. That authority includes the authority to extend the limitations periods set forth in this section as to specific age group categories in specific policy forms, based on the board's first finding that such an extension is in the best interest of the public.

Revisor's Note

Section 3(e), V.T.I.C. Article 3.70-12, refers to a long-term care "certificate." Throughout this chapter, the revised law omits "certificate" as unnecessary in this context because the term is included in the meaning of "long-term care benefit plan" as defined in Section 1651.003.

Revised Law

Sec. 1651.053. LOSS RATIO STANDARDS. (a) A long-term care benefit plan must provide a benefit plan holder with benefits that are reasonable in relation to the rates charged.

(b) The commissioner shall adopt reasonable rules to establish minimum standards for loss ratios of long-term care benefit plans on the basis of:

(1) incurred claims experience;

(2) earned premiums;

(3) the period for which rates are computed to provide coverage;

(4) experienced and projected trends;

(5) concentration of experience within early benefit plan duration;

(6) expected claim fluctuations;

(7) experience refunds;

(8) adjustments;

(9) dividends;

(10) renewability features;

(11) all relevant expense factors;

(12) interest;

(13) reserves;

(14) mix of business by risk classification; and

(15) product features otherwise affecting claims experience.

(c) Annually, each entity providing a long-term care benefit plan in this state shall:

(1) file its rates, rating schedule, and supporting documentation to demonstrate compliance with the applicable loss ratio standards of this state; and

(2) comply with any other filing requirement adopted by the commissioner relating to loss ratios.

(d) Rules adopted under this section shall be no less favorable to the holders of long-term care benefit plans than any model laws, rules, and regulations adopted in connection with minimum standards for benefits for long-term care benefit plans. (V.T.I.C. Art. 3.70-12, Sec. 4.)

Source Law

> Sec. 4. (a) Long-term care insurance policies shall return to holders of the policies benefits that are reasonable in relation to the premium charged. The State Board of Insurance shall adopt reasonable rules to establish minimum standards for loss ratios of long-term care insurance policies on the basis of incurred claims experience, earned premiums, the period for which rates are computed to provide coverage, experienced and projected trends, concentration of experience within early policy duration, expected claim fluctuation, experience refunds, adjustments, dividends, renewability features, all relevant expense factors, interest, policy reserves, mix of business by risk classification, and product features otherwise

affecting claims experience.

(b) Each entity providing long-term care insurance in this state annually shall file its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this state, as well as any other filing requirements relating to loss ratios promulgated under rules adopted by the State Board of Insurance.

(c) The State Board of Insurance shall adopt reasonable rules providing loss ratio standards applicable to rates charged for long-term care insurance policies. The rules adopted shall be no less favorable to the holders of those policies than any model laws, rules, and regulations adopted in connection with minimum standards for benefits for long-term care insurance.

Revised Law

Sec. 1651.054. NOTICE OF RIGHT TO REFUND. (a) In this section, "applicant" means:

(1) in the case of an individual long-term care benefit plan, the individual who seeks to contract for insurance or other health benefits; and

(2) in the case of a group long-term care benefit plan, the proposed certificate holder.

(b) A long-term care benefit plan must have a notice prominently printed on the first page of or attached to the benefit plan document.

(c) The notice must state in substance that, if the applicant is not satisfied for any reason after examining the benefit plan document, the applicant is entitled to:

(1) return the document not later than the 30th day after the date of its delivery; and

(2) have any premium refunded.

(d) The long-term care benefit plan issuer shall pay in a timely manner the refund directly to the individual or entity that paid the premium. (V.T.I.C. Art. 3.70-12, Secs. 2(1), 5.)

Source Law

Sec. 2. In this article:

(1) "Applicant" means:

(A) in the case of an individual long-term care insurance policy, the person who seeks to contract for insurance or other health benefits; and

(B) in the case of a group long-term care insurance policy, the proposed certificate

holder.

Sec. 5. Each long-term care insurance policy or certificate must have a notice prominently printed on the first page of or attached to the policy or certificate stating in substance that the applicant has the right to return the policy or certificate within 30 days of the date of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. The entity issuing the policy or certificate shall pay in a timely manner a refund made under this section directly to the person or entity that remitted the premium.

Revised Law

Sec. 1651.055. RATE STABILIZATION. (a) The commissioner shall adopt rules to stabilize long-term care premium rates by:

(1) ensuring that:

(A) initial rates for long-term care benefit plan forms are adequate; and

(B) any rate schedule increases for long-term care benefit plans made after issuance of the plans are justified, adequate, and reasonable in relation to benefits provided to plan holders;

(2) requiring any appropriate plan terms;

(3) imposing penalties on insurers or other entities subject to this chapter that violate a rule adopted under this section; and

(4) protecting plan holders affected by a rate schedule increase.

(b) Except as provided by this subsection, the commissioner shall adopt rules under this section that are consistent with nationally recognized models relating to the stabilization of long-term care premium rates that existed on January 1, 2001. The commissioner may adopt rules consistent with any of those models as they are amended after January 1, 2001. The commissioner shall adopt rules under this subsection that:

(1) to the extent possible, contribute to the uniformity of state laws; and

(2) protect consumers.

(c) In adopting rules under this section, the commissioner

may exempt long-term care benefit plans from the requirements of Sections 1651.053(a), (b), and (d). (V.T.I.C. Art. 3.70-12, Sec. 5A.)

Source Law

Sec. 5A. (a) The commissioner shall adopt rules to stabilize long-term care insurance premium rates by:

(1) ensuring that:

(A) initial rates for long-term care insurance policy forms are adequate; and

(B) any rate schedule increases for long-term care insurance policies made after issuance of the policies are justified, adequate, and reasonable in relation to benefits provided to policy or certificate holders;

(2) requiring any appropriate policy terms;

(3) imposing penalties on insurers or other entities subject to this article that violate a rule adopted under this section; and

(4) protecting policy and certificate holders affected by a rate schedule increase.

(b) Except as provided by this subsection, the commissioner shall adopt rules under this section that are consistent with nationally recognized models relating to the stabilization of long-term care insurance premium rates that existed on January 1, 2001. The commissioner may adopt rules consistent with any of those models as they are amended after January 1, 2001. The commissioner shall adopt rules under this subsection that:

(1) to the extent possible, contribute to the uniformity of state laws; and

(2) protect consumers.

(c) In adopting rules under this section, the commissioner may exempt long-term care insurance policies from the requirements of Sections 4(a) and (c) of this article.

CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1652.006-1652.050 reserved for expansion]

SUBCHAPTER B. BENEFITS

CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1652.001. DEFINITIONS. In this chapter:

(1) "Applicant" means:

(A) an individual who seeks to contract for insurance or other health benefits under an individual Medicare

supplement benefit plan; or

(B) the proposed certificate holder of a group Medicare supplement benefit plan.

(2) "Approved regulatory program" means a state regulatory program that complies with the requirements of Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(3) "Medicare" means the Health Insurance for the Aged Act (42 U.S.C. Section 1395 et seq.), as amended. (V.T.I.C. Art. 3.74, Secs. 1(b)(1), (4); New.)

Source Law

(b) Definitions.

(1) "Applicant" means:

(A) in the case of an individual medicare supplement policy, the person who seeks to contract for insurance or other health benefits, and

(B) in the case of a group medicare supplement policy, the proposed certificate holder.

(4) "Medicare" means the Health Insurance for the Aged Act, Part 1 of Title I of the Social Security Amendments of 1965, as amended (Public Law 89-97).

Revisor's Note

(1) Section 1(b)(1), V.T.I.C. Article 3.74, refers to a "medicare supplement policy." The revised law substitutes "benefit plan" for "policy" because V.T.I.C. Article 3.74, revised as this chapter, applies to evidences of coverage issued by health maintenance organizations to supplement reimbursements under Medicare. Health maintenance organizations provide health benefit coverage, but the organizations are not insurers, which issue policies. Consequently, "benefit plan" is a more accurate term than "policy." The substitution of "benefit plan" and comparable changes necessary to ensure consistency in terminology are made throughout this chapter.

(2) Section 1(b)(4), V.T.I.C. Article 3.74, refers to the "Health Insurance for the Aged Act, Part 1 of Title I of the Social Security Amendments of 1965,

as amended (Public Law 89-97)." The correct citation for that federal law is 42 U.S.C. Section 1395 et seq., and the revised law is drafted accordingly.

(3) The definition of "approved regulatory program" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 1652.002. MEDICARE SUPPLEMENT BENEFIT PLAN. (a) "Medicare supplement benefit plan" means a group or individual policy of accident and health insurance, a subscriber contract of a group hospital service corporation operating under Chapter 842, or, to the extent required by federal law, an evidence of coverage issued by a health maintenance organization operating under Chapter 843 that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of an individual eligible for Medicare.

(b) A policy, contract, subscriber contract, or evidence of coverage is not considered to be a Medicare supplement benefit plan if it is:

(1) a policy, contract, subscriber contract, or evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination, for employees or former employees, or a combination, or for members or former members, or a combination, of the labor organizations;

(2) a policy or health care benefit plan, including a policy or contract of group insurance, a group contract of a group hospital service corporation operating under Chapter 842, or a group evidence of coverage issued by a health maintenance organization operating under Chapter 843 that is not marketed or held to be a Medicare supplement benefit plan; or

(3) an individual or group evidence of coverage issued

in accordance with a contract under Section 1833 or 1876, Social Security Act (42 U.S.C. Section 1395l or 1395mm), by a health maintenance organization operating under Chapter 843.

(c) The commissioner by rule may modify the definition of "Medicare supplement benefit plan" provided by Subsection (a) to the extent necessary for this state to qualify as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 1(b)(3).)

Source Law

> (3) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of a hospital service corporation subject to Chapter 20 of this code or, to the extent required by federal law, an evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act, as amended (Chapter 20A, Vernon's Texas Insurance Code), which policy, subscriber contract, or such evidence of coverage is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare; provided that the State Board of Insurance may by rule modify the definition of medicare supplement policy to the extent necessary for the State of Texas to qualify as a state with an approved regulatory program under the provisions of Public Law 96-265, Section 507(a), 94 Stat. 476 (42 U.S.C.A. Section 1395ss (1980)). Such term does not include:
>
> (A) a policy, contract, subscriber contract, or evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations;
>
> (B) a policy or health care benefit plan including a policy or contract of group insurance or group contract of a hospital service corporation subject to Chapter 20 of this code or group evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), when such policy or plan is not marketed or held to be a medicare supplement policy or benefit plan; or
>
> (C) an individual or group evidence of coverage issued pursuant to a contract under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C.A. Section 1395, et seq.) by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

Revisor's Note

(1) Section 1(b)(3), V.T.I.C. Article 3.74, refers to a policy of "accident and sickness

insurance." For consistency with modern usage, the revised law substitutes "health" for "sickness."

(2) Section 1(b)(3), V.T.I.C. Article 3.74, refers to a "hospital service corporation" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "hospital service corporation" for consistency of terminology in this code.

(3) Section 1(b)(3), V.T.I.C. Article 3.74, refers to "Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C.A. Section 1395, et seq.)." The correct reference for those sections is "Section 1833 or 1876, Social Security Act (42 U.S.C. Section 1395l or 1395mm)," and the revised law is drafted accordingly.

(4) Section 1(b)(3), V.T.I.C. Article 3.74, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 1652.003. APPLICABILITY OF CHAPTER. This chapter applies to an individual or group Medicare supplement benefit plan delivered or issued for delivery in this state and, regardless of the place where the plan was delivered or issued for delivery, a certificate that was issued under a group Medicare supplement benefit plan and delivered or issued for delivery in this state, if the plan or certificate is issued by:

(1) a capital stock insurance company, including a

life, health and accident, and general casualty insurance company;

(2) a mutual life insurance company;

(3) a mutual assessment life insurance company, including a statewide mutual assessment company, local mutual aid association, and burial association;

(4) a mutual or mutual assessment association of any kind, including an association subject to Section 887.102;

(5) a mutual insurance company other than a life insurance company;

(6) a mutual or natural premium life or casualty insurance company;

(7) a fraternal benefit society;

(8) a Lloyd's plan;

(9) a reciprocal or interinsurance exchange;

(10) a nonprofit hospital, medical, or dental service corporation, including a corporation operating under Chapter 842;

(11) a stipulated premium company;

(12) another insurer that by law is required to be authorized by the department; or

(13) a health maintenance organization operating under Chapter 843, to the extent required by federal law. (V.T.I.C. Art. 3.74, Secs. 1(a) (part), (b)(2).)

Source Law

Art. 3.74

Sec. 1. (a) Scope of Article. Notwithstanding Section 2(b)(5) of Article 1.14-1 of this code, this article applies to and governs group and individual medicare supplement policies delivered or issued for delivery in this state and certificates issued under group medicare supplement policies that have been delivered or issued for delivery in this state if those policies or certificates are issued by capital stock companies, including but not limited to life, health and accident, and general casualty companies; mutual life insurance companies; mutual assessment life insurance companies, including but not limited to statewide mutual assessment corporations, local mutual aids, and burial associations; mutual and mutual assessment associations of all kinds and types, including but not limited to associations subject to Article 14.17 of this code; mutual insurance companies other than life; mutual or natural premium life or casualty insurance companies; fraternal benefit societies; Lloyds; reciprocal or inter-insurance

exchanges; nonprofit hospital, medical, or dental service corporations, including but not limited to companies subject to Chapter 20 of this code; stipulated premium insurance companies; or any other insurer which by law is required to be licensed by the State Board of Insurance; and, to the extent required by federal law, health maintenance organizations subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); provided, that . . . .

[(b)]

(2) "Certificate" means, for the purposes of this article, any certificate issued under a group medicare supplement policy, which certificate has been delivered or issued for delivery in this state regardless of the place where the policy was delivered or issued for delivery.

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 3.74, states that "[n]otwithstanding Section 2(b)(5) of Article 1.14-1 of this code, this article applies to and governs" certain policies. The revised law omits the reference to Section 2(b)(5), V.T.I.C. Article 1.14-1, as unnecessary. Section 2(b)(5), revised as Section 101.053(b)(5) of this code, describes the types of transactions that are not considered to be the business of insurance and therefore are not regulated under general Insurance Code provisions relating to insurance regulation. Because V.T.I.C. Article 3.74, revised as this chapter, provides explicit authority to regulate Medicare supplement benefit plans, including plans that otherwise would be described by Section 101.053(b)(5), it is not necessary to negate the effect of Section 2(b)(5), V.T.I.C. Article 1.14-1. The revised law omits "and governs" as unnecessary because the language does not add to the clear meaning of the law.

(2) Section 1(a), V.T.I.C. Article 3.74, refers to companies and associations, "including but not limited to" certain companies and associations. The revised law omits "but not limited to" as unnecessary because Section 311.005(13), Government Code (Code

Construction Act), and Section 312.011(19), Government Code, provide that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

(3) Section 1(a), V.T.I.C. Article 3.74, refers to any other insurer required by law to be "licensed" by the State Board of Insurance (now the Texas Department of Insurance). The revised law substitutes "authorized" for "licensed" for consistency of terminology within this code.

Revised Law

Sec. 1652.004. CONSTRUCTION OF CHAPTER. (a) This chapter may not be construed to enlarge the powers of an entity described by Section 1652.003.

(b) This chapter controls to the extent of any conflict with another provision of this code. (V.T.I.C. Art. 3.74, Secs. 1(a) (part), 7 (part).)

Source Law

Sec. 1. (a) . . . this article shall not be construed to enlarge the powers of any of the enumerated companies.

Sec. 7. . . . in the event of any conflict between the provisions of this article and any other provisions of the Insurance Code, the provisions of this article control to the extent of such conflict.

Revisor's Note

The revised law omits as unnecessary that part of Section 7, V.T.I.C. Article 3.74, relating to the cumulative effect of that article. An accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless it provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. The omitted law reads:

Sec. 7. The provisions of this article are cumulative of all other law, but

. . . .

Revised Law

Sec. 1652.005. RULES NECESSARY FOR CERTIFICATION. In addition to other rules required or authorized by this chapter, the commissioner shall adopt reasonable rules necessary and proper to carry out this chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certification as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 10.)

Source Law

> Sec. 10. In addition to other rules required or authorized by this article, the State Board of Insurance shall adopt rules in accordance with federal law applicable to the regulation of medicare supplement insurance coverage that are necessary for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss and any other reasonable rules that are necessary and proper to carry out this article.

[Sections 1652.006-1652.050 reserved for expansion]

SUBCHAPTER B. BENEFITS

Revised Law

Sec. 1652.051. MINIMUM STANDARDS. (a) The commissioner shall adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different Medicare supplement benefit plans. The standards are in addition to and must be in accordance with:

(1) applicable laws of this state, including Chapters 842 and 1201;

(2) applicable federal law, rules, regulations, and standards; and

(3) any model rules and regulations required by federal law, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(b) The standards may include provisions relating to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions, and reductions;

(6) elimination periods;

(7) requirements for replacement;

(8) recurrent conditions;

(9) definitions of terms; and

(10) exclusions required by state or federal law.

(c) The commissioner may adopt reasonable rules that specifically prohibit benefit plan provisions that:

(1) are not otherwise specifically authorized by statute; and

(2) the commissioner determines are unjust, unfair, or unfairly discriminatory to a person who is covered or proposed for coverage.

(d) Rules adopted under this section must include requirements that are at least equal to those required by federal law, rules, regulations, and standards, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 2(c), (d), (f).)

Source Law

(c) The State Board of Insurance shall issue reasonable rules to establish specific standards for provisions of medicare supplement policies and standards for facilitating comparison among the medicare supplement products of the insurer or entity offering such medicare supplement products. Such standards shall be in addition to and in accordance with applicable laws of this state, including but not limited to Subchapter G of Chapter 3, Chapter 20 of this Code, and applicable federal law, rules, regulations, and standards and any model rules and regulations required by 42 U.S.C. Section 1395ss and other federal law and may cover but shall not be limited to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions, and reductions;

(6) elimination periods;

(7) requirements for replacement;

(8) recurrent conditions;
(9) definitions of terms; and
(10) exclusions required by state or federal law.

(d) The State Board of Insurance may issue reasonable rules that specify prohibited provisions not otherwise specifically authorized by statute which, in the opinion of the State Board of Insurance, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy.

(f) The rules issued by the State Board of Insurance under this section must include requirements that are at least equal to those required by federal law, rules, regulations, and standards, including 42 U.S.C. Section 1395ss.

Revisor's Note

(1) Section 2(c), V.T.I.C. Article 3.74, refers to laws, "including but not limited to" certain laws. The revised law omits "but not limited to" for the reason stated in Revisor's Note (2) to Section 1652.003.

(2) Section 2(c), V.T.I.C. Article 3.74, refers to standards that "may cover but shall not be limited to" certain terms. The revised law substitutes "include" for "cover" because the terms are synonymous in context and omits "but shall not be limited to" for the reason stated in Revisor's Note (2) to Section 1652.003.

Revised Law

Sec. 1652.052. MINIMUM STANDARDS FOR BENEFITS AND CLAIM PAYMENTS. (a) The commissioner shall adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

(b) The standards for benefits and claim payments must include the requirements for certification of Medicare supplement benefit plans prescribed by Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 3.)

Source Law

Sec. 3. (a) The State Board of Insurance shall issue reasonable rules to establish minimum standards for benefits and claim payments under medicare supplement policies.

(b) Minimum standards for benefits and claim payments shall include the requirements for certification of medicare supplement policies as provided by 42 U.S.C. Section 1395ss.

Revised Law

Sec. 1652.053. DUPLICATE BENEFITS PROHIBITED. A Medicare supplement benefit plan or certificate in force in this state may not contain benefits that duplicate benefits provided by Medicare. (V.T.I.C. Art. 3.74, Sec. 2(a).)

Source Law

Sec. 2. (a) No medicare supplement insurance policy or certificate in force in this state shall contain benefits that duplicate benefits provided by medicare.

Revised Law

Sec. 1652.054. BASIC PLAN. An entity described by Section 1652.003 that offers for sale in this state a Medicare supplement benefit plan must offer a basic Medicare supplement benefit plan that:

(1) provides only those benefits common to all Medicare supplement benefit plans; and

(2) meets but does not exceed the minimum standards of benefits for Medicare supplement benefit plans adopted by the commissioner and authorized by Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 2(b) (part).)

Source Law

(b) Any insurer or other entity designated in Section 1(a) of this article that offers for sale in this state a medicare supplement insurance policy must offer a basic medicare supplement policy that provides only those benefits common to all medicare supplement policies, and that meets, but does not exceed the minimum standards of benefits for medicare supplement policies authorized by 42 U.S.C. Section 1395ss and adopted by the board. . . .

Revisor's Note

Section 2(b), V.T.I.C. Article 3.74, refers to an "insurer or other entity" designated under Section 1(a) of that article. The revised law substitutes "entity" for "insurer or other entity" because the

terms are synonymous in context. Similar changes are made throughout this chapter.

Revised Law

Sec. 1652.055. ADDITIONAL BENEFITS. (a) In addition to the basic Medicare supplement benefit plan described by Section 1652.054, an entity may offer additional Medicare supplement benefit plans for sale in this state.

(b) The combination of benefits provided by an additional plan must conform to one of the benefit packages adopted by the commissioner and authorized by Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(c) The commissioner by rule shall provide for the approval of new or innovative benefits that may be provided in a plan other than the basic plan and that otherwise comply with this subchapter. The benefits must:

(1) be offered in a manner consistent with the goal of Medicare supplement benefit plan simplification; and

(2) meet the requirements prescribed by Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 2(b) (part).)

Source Law

> (b) . . . In addition to this basic medicare supplement insurance policy, any such insurer or other entity may offer for sale in this state additional medicare supplement policies. The combination of benefits provided by the additional policies must conform to one of the benefit packages authorized by 42 U.S.C. Section 1395ss and adopted by the board. The board by rule shall provide for the approval of new or innovative benefits that may be provided in a policy other than the basic policy and that otherwise comply with this section. The new or innovative benefits shall be offered in a manner consistent with the goal of medicare supplement policy simplification and shall meet the requirements set forth in 42 U.S.C. Section 1395ss.

Revised Law

Sec. 1652.056. COVERAGE FOR MAMMOGRAPHY. (a) In this section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens,

films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

(b) Each Medicare supplement benefit plan must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer.

(c) The coverage for the annual screening may not be less favorable than coverage for other radiological examinations and must be subject to the same dollar limits, deductibles, and coinsurance factors. (V.T.I.C. Art. 3.74, Sec. 3A.)

Source Law

> Sec. 3A. (a) In this section, "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.
>
> (b) Each Medicare supplement policy delivered, issued for delivery, or renewed in this state must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer within the provisions of the policy that is not less favorable than for other radiological examinations and subject to the same dollar limits, deductibles, and co-insurance factors.

Revised Law

Sec. 1652.057. WAIVER OF WAITING PERIOD. (a) An entity that delivers or issues for delivery in this state a Medicare supplement benefit plan or certificate that replaces a Medicare supplement benefit plan or certificate shall give credit for the satisfaction or partial satisfaction of any waiting period, elimination period, or probationary period for a preexisting condition that has been satisfied under the plan being replaced.

(b) A replacement plan that clearly provides a new or additional benefit may include appropriate and clearly stated periods as a condition for payment of the new or additional benefit. (V.T.I.C. Art. 3.74, Sec. 8.)

Source Law

> Sec. 8. An insurer or other entity that delivers or issues for delivery a medicare supplement policy or certificate in this state that replaces an existing medicare supplement policy or certificate shall give

credit for the satisfaction or partial satisfaction of any waiting periods, elimination periods, and probationary periods that are applicable to preexisting conditions and that have already been satisfied under the policy being replaced. Any new or additional benefits that are clearly set forth in the replacement policy may include appropriate clearly stated time periods as a condition of payment for such new or additional benefits.

Revised Law

Sec. 1652.058. COVERAGE FOR PREEXISTING CONDITION. (a) A Medicare supplement benefit plan may not contain a provision that excludes coverage for a claim for losses incurred more than six months after the effective date of coverage for a preexisting condition.

(b) A Medicare supplement benefit plan may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage. (V.T.I.C. Art. 3.74, Sec. 2(e).)

Source Law

(e) Notwithstanding any other provisions of the law, a medicare supplement policy may not deny a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. Such policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

[Sections 1652.059-1652.100 reserved for expansion]

SUBCHAPTER C. LOSS RATIO STANDARDS

Revised Law

Sec. 1652.101. LOSS RATIO STANDARDS. (a) A Medicare supplement benefit plan must return to a plan holder benefits that are reasonable in relation to the premium charged.

(b) The commissioner shall adopt reasonable rules to establish minimum loss ratio standards for Medicare supplement benefit plans. The standards must be established:

(1) on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage;

(2) in accordance with accepted actuarial principles and practices; and

(3) to the extent necessary for the state to obtain or retain certification as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Secs. 4(a), (d).)

Source Law

> Sec. 4. (a) Medicare supplement policies shall return to holders of a medicare supplement policy benefits which are reasonable in relation to the premium charged. The State Board of Insurance shall issue reasonable rules to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices.
>
> (d) The State Board of Insurance shall issue reasonable rules providing loss ratio standards applicable to rates charged for medicare supplement policies to the extent necessary for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss.

Revised Law

Sec. 1652.102. FILING REQUIREMENTS. (a) Annually, each entity providing Medicare supplement benefit plans in this state shall file with the department the entity's rates, rating schedule, and supporting documentation demonstrating that:

(1) the entity is complying with the applicable loss ratio standards of this state; and

(2) the actual and expected losses in relation to premiums comply with the requirements of this subchapter and the rules adopted by the commissioner.

(b) The documentation required by Subsection (a) must include a report of the ratio of incurred losses to covered premiums for the preceding calendar year, illustrated by calendar year of issue.

(c) The commissioner may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios. (V.T.I.C. Art. 3.74, Secs. 4(b), (c).)

Source Law

(b) Every entity providing medicare supplement policies or benefits in this state shall file annually its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this state. The supporting documentation must include a report of the ratio of incurred losses to covered premiums for the preceding calendar year, illustrated by calendar year of issue. The board may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios.

(c) All filings of rates, rating schedules, and loss ratios must demonstrate that the actual and expected losses in relation to premiums comply with the requirements of this section and rules adopted by the board.

Revised Law

Sec. 1652.103. REVIEW OF PREMIUM INCREASES. (a) The commissioner by rule shall provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

(b) The rules must comply with federal law, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 4(f).)

Source Law

(f) The board by rule shall provide a process for review and approval or disapproval of proposed premium increases with respect to medicare supplement policies or benefits. Any rules adopted by the board under this subsection must comply with 42 U.S.C. Section 1395ss and other federal law.

Revised Law

Sec. 1652.104. BENEFIT CHANGES. (a) Before the date on which a Medicare benefit change required by federal law takes effect, each entity providing in this state a Medicare supplement benefit plan existing on the effective date of the change shall file with the commissioner, in accordance with Chapter 1701:

(1) each appropriate premium adjustment necessary to produce the loss ratios originally anticipated for the applicable plan, accompanied by any supporting documents necessary to justify the adjustment; and

(2) each appropriate rider, endorsement, or plan form necessary to modify the coverage so as to eliminate benefit

duplications with Medicare.

(b) A rider, endorsement, or plan form required by Subsection (a) must provide a clear description of the Medicare supplement benefits provided by the plan. (V.T.I.C. Art. 3.74, Sec. 4(e).)

Source Law

> (e) Before the effective date of any medicare benefit changes required by federal law as applicable to existing policies, every insurer, health care service plan, or other entity providing medicare supplement insurance or contracts in this state shall file with the commissioner, in accordance with Article 3.42 of this code:
>
> (1) appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts, and such supporting documents as necessary to justify the adjustment shall accompany the filing; and
>
> (2) appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement insurance modifications necessary to eliminate benefit duplications with medicare.
>
> Those riders, endorsements, or policy forms shall provide a clear description of the medicare supplement benefits provided by the policy or contract.

Revised Law

Sec. 1652.105. REPORTING LOSS RATIO INFORMATION TO SECRETARY OF HEALTH AND HUMAN SERVICES. To the extent necessary for this state to obtain or retain certification as a state with an approved regulatory program, the department shall comply with federal requirements relating to periodic reporting of loss ratio information to the secretary of health and human services, based on a uniform methodology, as authorized by federal law. (V.T.I.C. Art. 3.74, Sec. 4(g).)

Source Law

> (g) The board shall comply with federal requirements relating to periodical reporting on loss ratio information to the Secretary of Health and Human Services, based on uniform methodology for reporting loss ratios, as authorized by federal law to the extent necessary for this state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss.

[Sections 1652.106-1652.150 reserved for expansion]

SUBCHAPTER D. CONSUMER INFORMATION AND NOTICE

Revised Law

Sec. 1652.151. RULES RELATING TO DISCLOSURE. The rules adopted under Sections 1652.152, 1652.153, and 1652.154 must include provisions and requirements that are at least equal to those required by federal law, including the rules, regulations, and standards adopted under Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 5(b) (part), (f).)

Source Law

> (b) . . . The rules adopted by the board governing the outline of coverage must include provisions at least equal to those required by rules, regulations, and standards adopted under 42 U.S.C. Section 1395ss or required by other federal law.
>
> (f) Any rules adopted by the board under this section must include requirements that are at least equal to those required by rules, regulations, and standards adopted under 42 U.S.C. Section 1395ss or required by other federal law.

Revised Law

Sec. 1652.152. OUTLINE OF COVERAGE. (a) To provide for full and fair disclosure in the sale of Medicare supplement benefit plans, a Medicare supplement benefit plan or certificate may not be delivered or issued for delivery in this state unless an outline of coverage that complies with this section is delivered to the applicant when the applicant applies for the coverage.

(b) The commissioner by rule shall prescribe the format and content of the outline of coverage required by Subsection (a). The rules must address the style, arrangement, and overall appearance of the outline of coverage, including the size, color, and prominence of type and the arrangement of text and captions. (V.T.I.C. Art. 3.74, Secs. 5(a), (b) (part).)

Source Law

> Sec. 5. (a) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered or issued for delivery in this state unless an outline of coverage complying with the

requirements of this section is delivered to the applicant at the time application is made.

(b) The State Board of Insurance by rule shall prescribe the format and content of the outline of coverage required by Subsection (a) of this section. For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. . . .

Revised Law

Sec. 1652.153. INFORMATIONAL BROCHURE. (a) The commissioner by rule may prescribe a standard form and the contents of an informational brochure intended to improve the ability of an individual eligible for Medicare to understand Medicare and to select the most appropriate Medicare supplement coverage.

(b) Except as provided by Subsection (c), the commissioner by rule may require that the informational brochure be provided to an individual eligible for Medicare concurrently with delivery of the outline of coverage.

(c) If the plan is a direct response Medicare supplement benefit plan, the commissioner by rule may require that the informational brochure be provided on request to an individual eligible for Medicare at any time not later than the time the plan is delivered. (V.T.I.C. Art. 3.74, Sec. 5(c).)

Source Law

(c) The State Board of Insurance may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response medicare supplement policies, the State Board of Insurance may require by rule that the informational brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response medicare supplement policies, the State Board of Insurance may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare but in no event later than the time of policy delivery.

Revisor's Note

Section 5(c), V.T.I.C. Article 3.74, refers to "prospective insureds eligible for medicare." The revised law omits "prospective insureds" as redundant

because an individual eligible for Medicare is also a "prospective insured."

Revised Law

Sec. 1652.154. NOTICE RELATING TO OTHER TYPES OF COVERAGE. (a) The commissioner may adopt reasonable rules for captions or notice requirements for each accident and health insurance policy, subscriber contract, or evidence of coverage sold to an individual eligible for Medicare that are determined to be in the public interest and designed to inform the individual that a particular coverage is not a Medicare supplement benefit plan. This subsection does not apply to:

(1) a Medicare supplement benefit plan;

(2) a disability income policy;

(3) a basic, catastrophic, or major medical expense policy;

(4) a single premium nonrenewable policy; or

(5) another policy, contract, or subscriber contract described by Section 1652.002(b)(1) or (2).

(b) The commissioner may adopt reasonable rules to govern the full and fair disclosure of information relating to replacing an accident and health insurance policy, a subscriber contract, or a certificate by an individual eligible for Medicare. (V.T.I.C. Art. 3.74, Secs. 5(d), (e).)

Source Law

(d) The State Board of Insurance may promulgate reasonable rules for captions or notice requirements determined to be in the public interest and designed to inform prospective insureds, subscribers, or enrollees that particular coverages are not medicare supplement coverages for all accident and sickness insurance policies or subscriber contracts or evidences of coverage sold to persons eligible for medicare, other than:

(1) medicare supplement policies;

(2) disability income policies;

(3) basic, catastrophic, or major medical expense policies;

(4) single premium nonrenewable policies; or

(5) other policies, contracts, or subscriber contracts as specified in Paragraphs (A) and (B) of Subsection (b) of Section 1 of this article.

(e) The State Board of Insurance may further

promulgate reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts, or certificates by persons eligible for medicare.

Revisor's Note

(1) Section 5(d), V.T.I.C. Article 3.74, refers to "prospective insureds, subscribers, or enrollees." The revised law substitutes "individual eligible for Medicare" for consistency of terminology in this chapter. An individual eligible for Medicare is also a "prospective insured, subscriber, or enrollee."

(2) Sections 5(d) and (e), V.T.I.C. Article 3.74, refer to "accident and sickness" insurance policies. The revised law substitutes "health" for "sickness" for the reason stated in Revisor's Note (1) to Section 1652.002.

(3) Section 5(d)(5), V.T.I.C. Article 3.74, refers to policies, contracts, or subscriber contracts as specified in "Paragraphs (A) and (B) of Subsection (b) of Section 1 of this article." It is apparent from the context of the source law that the correct cross-reference is Sections 1(b)(3)(A) and (B), revised as Sections 1652.002(b)(1) and (2), and the revised law is drafted accordingly.

Revised Law

Sec. 1652.155. RIGHT TO RETURN FOR REFUND; NOTICE. (a) If an applicant is not satisfied for any reason after examining a Medicare supplement benefit plan document or certificate, the applicant is entitled to receive a refund of the premium if the applicant returns the document or certificate not later than the 30th day after the date it is delivered.

(b) The entity issuing the plan or certificate shall refund the premium directly to the applicant in a timely manner.

(c) A Medicare supplement benefit plan or certificate must have a notice stating the substance prescribed by Subsection (a)

prominently printed on the first page of or attached to the plan or certificate. (V.T.I.C. Art. 3.74, Sec. 6.)

Source Law

> Sec. 6. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of such policy or certificate or attached thereto stating in substance that the applicant shall have the right to return such policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of such policy or certificate, the applicant is not satisfied for any reason. A refund made pursuant to this section must be paid directly to the applicant in a timely manner by the entity issuing the policy or certificate.

Revised Law

Sec. 1652.156. ADVERTISING FILING REQUIREMENTS. (a) The commissioner shall adopt reasonable rules to require each entity described by Section 1652.003 to file with the department a copy of any advertisement relating to Medicare supplement benefit plans that the entity intends to use in this state. The rules must require that the entity file the copy not later than the 60th day before the date of intended use.

(b) At the expiration of the 60-day period provided by Subsection (a), an advertisement filed in accordance with that subsection is considered acceptable, unless before the end of that 60-day period the department notifies the entity of the advertisement's nonacceptance.

(c) An entity may not use an advertisement for Medicare supplement benefit plans that does not comply with state law, including department rules. (V.T.I.C. Art. 3.74, Sec. 9.)

Source Law

> Sec. 9. (a) The State Board of Insurance shall issue reasonable rules to require each entity designated in Section 1(a) of this article that delivers or issues for delivery in this state a group or individual medicare supplement policy or certificate to file with the State Board of Insurance, not later than the 60th day before the date of the intended use of the advertisement, a copy of the advertisement that is intended for use in this state and that relates to medicare supplement insurance. The advertisement must comply with applicable law of this state and rules of the State Board of Insurance.
>
> (b) At the expiration of the 60-day period provided by Subsection (a) of this section, any

advertisement that is filed under that subsection shall be deemed acceptable, unless before the end of that 60-day period the board has notified the entity of its nonacceptance.

(c) An entity may not use an advertisement for medicare supplement insurance that does not comply with this state's law and the board's rules.

Revisor's Note

Section 9(a), V.T.I.C. Article 3.74, refers to an "entity designated in Section 1(a) of this article that delivers or issues for delivery in this state a group or individual medicare supplement policy or certificate." The revised law omits the reference to "delivers or issues for delivery in this state a group or individual medicare supplement policy or certificate" because an entity "designated" by Section 1(a), V.T.I.C. Article 3.74, revised as Section 1652.003, is by the terms of Section 1(a) such an entity.

[Sections 1652.157-1652.200 reserved for expansion]

SUBCHAPTER E. AGENTS

Revised Law

Sec. 1652.201. INFORMATION PROVIDED TO AGENTS. (a) An entity that offers a Medicare supplement benefit plan for sale in this state shall provide to each agent authorized to sell that plan information relating to:

(1) Medicare;

(2) the Medicare supplement benefit plans offered by that entity; and

(3) the agent's ethical obligations to clients.

(b) The commissioner by rule may prescribe the information that must be provided under this section. (V.T.I.C. Art. 3.74, Sec. 9A.)

Source Law

Sec. 9A. (a) Any insurer or other entity that offers for sale in this state a medicare supplement policy shall provide to each agent authorized to sell its medicare supplement policies information related to medicare, the medicare supplement policies offered by the insurer or other entity, and the agent's ethical

obligations to clients.

(b) The State Board of Insurance may prescribe by rule the information that must be provided under this section.

Revised Law

Sec. 1652.202. PERMITTED COMPENSATION ARRANGEMENTS. (a) The commissioner by rule shall limit the commission or other compensation that may be paid to an agent for the sale of a Medicare supplement benefit plan or certificate, including a replacement plan or certificate.

(b) The rules must conform to, but may not be more restrictive than, the requirements of federal law necessary for this state to obtain or retain certification as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 9B.)

Source Law

Sec. 9B. The board shall adopt rules limiting the commission or other compensation that may be paid to an agent for the sale of a medicare supplement policy or certificate, including replacement policies or certificates. Rules adopted by the board under this section must conform to, but may not be more restrictive than, the requirements of federal law that must be met for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss.

TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

CHAPTER 1701. POLICY FORMS

TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

CHAPTER 1701. POLICY FORMS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1701.006-1701.050 reserved for expansion]

SUBCHAPTER B. FILING REQUIREMENT